CHILD DEATH & SERIOUS INJURY
REVIEW COMMITTEE

Annual Report 2018–2019

Government
of South Australia

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Letter of Transmission

Hon John Gardner MP
Minister for Education

Dear Minister

I submit to you for presentation to Parliament, the 2018-19 Annual Report of the South Australian Child Death and Serious Injury Review Committee which has been prepared pursuant to Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

This report highlights the Committee's activities in fulfilling its statutory obligations.

In compliance with the *Public Sector Act 2009* and the *Public Finance and Audit Act 1987*, a further report concerning the management of human resources and financial issues of the Committee has been submitted as part of the Annual Report of the Department for Education for 2018-19.

Submitted on behalf of the Child Death and Serious Injury Review Committee by:

Meredith Dickson
Chair
Child Death and Serious Injury Review Committee
31 October 2019

Chair's Foreword

On behalf of the Child Death and Serious Injury Review Committee, I am pleased to present to Parliament, the Committee's 14th annual report. This report is provided under Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

This is the first report presented since I became Chair of the Committee in July 2018, following the retirement of the inaugural Chair, Ms Dymphna Eszenyi. It has been a busy and interesting year, and for me, a steep learning curve as I have come to grips with the work undertaken by the Committee.

This work is, by its very nature, confronting and at times distressing. The members of the Committee and the Secretariat are deeply committed to building systems that best address children's safety, and I thank them for their time and efforts.

On behalf of the Committee, I would also like to thank the Minister for Education, Mr John Gardner, and his staff, who have been very approachable and supportive. The Committee has submitted in-depth reviews about the deaths of three children to the Minister in this reporting period, providing him with information about the circumstances of these deaths, and recommending changes to the systems that provide services to children and their families.

During this year, I have had the opportunity to meet with many other bodies and individuals also working to improve the safety, wellbeing and development of South Australia's children. Most recently I spoke with the Commissioner for Aboriginal Children and Young People, and given the comparatively high rate of death of Aboriginal children, I anticipate that the Committee will continue to work with the Commissioner, to improve the lives of Aboriginal children in this state.

A child's death is a tragedy, and the Committee extends its sympathy to the families, friends, communities, and professionals who have cared for those children.

The Committee trusts that this report will assist the efforts of those who work to keep children safe, and will be of assistance to other professionals who work in this most challenging area.

Meredith Dickson
Chair
Child Death and Serious Injury Review Committee

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Glossary

ABS	Australian Bureau of Statistics
Act	*Children and Young People (Oversight and Advocacy Bodies) Act 2016*
ANZCDR & PG	Australian and New Zealand Child Death Review and Prevention Group
CAMHS	Child and Adolescent Mental Health Services
CDSIRC	Child Death and Serious Injury Review Committee
CFARN	Child and Family Assessment and Referral Network
Children	In this report 'children' includes infants, children and young people from birth up to 18 years
DCP	Department for Child Protection
ICD–10	International Classification of Disease (Version 10)
Infant	A child less than one year of age
SEIFA	Socio-Economic Indexes for Areas, Index of Relative Socio-economic Disadvantage (IRSD)
SIDS	Sudden Infant Death Syndrome
SUDI	Sudden Unexpected Death in Infancy
TAC	Team around the Child
WCH	Women's and Children's Hospital

Acknowledgements

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDR & PG)
- Births, Deaths and Marriages
- Department of Human Services which continues to provide technical advice and support for the Committee's database, and assistance with records management
- Department for Education for support with administrative, financial and human resource management
- Kidsafe SA
- National Centre for Health Information Research and Training, Brisbane, especially Ms Sue Walker, Director
- SA Health for support from the Data and Reporting Services, and the Pregnancy Outcome Unit
- SA Health Local Health Network staff and the staff of SA Pathology for their prompt responses to the Committee's requests for information
- SA Police for their diligent attention to collecting information about child deaths
- State Coroner and staff
- Chief Executives and senior officers from the Department for Child Protection, the Department for Education, the Department of Human Services, SA Health and SA Police for contributing to the Committee's understanding of service delivery within their departments.

Committee Members

Chair

Ms Meredith Dickson	from 9 July 2018

Members

Dr Mike Ahern	
Ms Melissa Bradley	from 1 July 2018
Ms Angela Davis	
Dr David Everett OAM	from 8 October 2018
Dr Mark Fuller	
Ms Dianne Gursansky	
Ms Ann-Marie Hayes	
Dr Deepa Jeyaseelan	
Dr Margaret Kyrkou OAM	
Mr William Thompson	from 1 July 2018
Mr Philip Robinson PSM	
Ms Kerrie Sellen	until 5 October 2018
Ms Barbara Tiffin	until 26 October 2018

Executive Summary

This is the fourteenth annual report of the Child Death and Serious Injury Review Committee.

This report provides a summary of the Committee's analyses and reviews of child deaths and serious injuries, and the steps it has taken to make and monitor the implementation of findings and recommendations arising from them.

Between 2005 and 2018:

- the leading causes of death for South Australia's children are those attributed to illness or disease, especially for infants under one year of age
- deaths due to drowning, a deliberate act by another person, and fire-related deaths all peak in the one to four year age group
- transport-related incidents are the most common cause of death for young people aged 15-17 years
- a higher number of children died in areas of the state where there were greater levels of socioeconomic disadvantage
- twenty-eight percent of children who have died, or their families, had had contact with the child protection system in the three years prior to their deaths
- across all categories of death – illness or disease, external causes and undetermined causes – the death rate is higher for Aboriginal children than for non-Aboriginal children
- twenty-two percent of children who died had a disability or disabilities which significantly limited their daily activities.

Three in-depth reviews were submitted to the Minister for Education in this reporting period.

A review into the death of a young Aboriginal child prompted recommendations about: the ways in which the child protection system holds itself responsible and accountable for a child's safety; the co-ordination of efforts between government agencies, and each agency's accountability for the safety of a child; the Department for Education's ways of monitoring and responding to issues of absenteeism, truancy, suspension and exclusion when a child's safety is in question; and, for all agencies, the ways in which standards of service delivery to Aboriginal children are addressed.

A review into the death of a child with disabilities who was in the care of the State, found that generally, systems had worked well to provide this child with a good quality of life. However, the review provided further evidence of the need for the child protection system to continue to support young people who have been in the care of the State, beyond the age of 18 years.

A second review into the death of a child with disabilities who was receiving services from multiple agencies, found that each agency worked diligently to try to improve the quality of this child's life. The adoption of a model of service delivery such as the 'team around the child', may have resulted in a more collaborative and integrated support system for this child and the family, that more effectively addressed the child's complex needs.

Responses to the Committee's recommendations have been received from several Ministers and are provided in this report. In addition to monitoring the implementation of these and previous recommendations, during this reporting period the Committee has provided more detailed and varied information through the quarterly release of topic-specific analyses on the Committee's website, and through presentations targeted to the interests of legislators, policy-makers and practitioners engaged in the provision of services to children and their families.

Section One

1. Child Deaths South Australia 2005–18

S37 – Functions of the Committee

(1) The functions of the Committee are –

a. to review cases in which children die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future; and

b. to make, and monitor the implementation of, recommendations for avoiding preventable child death or serious injury; and

c. to maintain a database of child deaths and serious injuries and their circumstances and causes.

Children and Young People (Oversight and Advocacy Bodies) Act 2016

1.1. Analysis and review of child deaths

The intent of the Committee is to improve the safety and wellbeing of children in South Australia. It does this by collecting information about the circumstances and causes of all child deaths in South Australia, analysing and reviewing this information, making recommendations to government, and monitoring the implementation of those recommendations. The Committee reviews specific cases of child death, and from time to time also reviews and analyses information about serious injuries.

1.2. Rates and patterns of death

Opportunities for prevention and intervention to improve the safety and wellbeing of children, can be identified through the systemic collection and analysis of information about child deaths. The *Children and Young People (Oversight and Advocacy Bodies) Act 2016*, S37[1] identifies those deaths as eligible for review if (a) the incident resulting in the child's death or serious injury occurred in the state; or (b) the child was, at the time of the death or serious injury, ordinarily resident in the state.

As required by the Act, the Committee maintains a database of child deaths and serious injuries, to which it continually adds information that informs its analyses about rates and patterns of child death in South Australia. Figure 1[2] shows death rates for all children who died in South Australia during the 14 years from 2005 to 2018, and Figure 2 shows death rates for only those children who were usual residents of South Australia. During these 14 years, the average yearly population of children aged 0 to 17, was 356 013[3].

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[1] *https://www.legislation.sa.gov.au/LZ/C/A/CHILDREN%20AND%20YOUNG%20PEOPLE%20(OVERSIGHT%20AND%20ADVOCACY%20BODIES)%20ACT%202016.aspx*

[2] *For each figure in Section One, there is a corresponding data table in Section 4.*

[3] *For more information on how this number was calculated, see Section 3.*

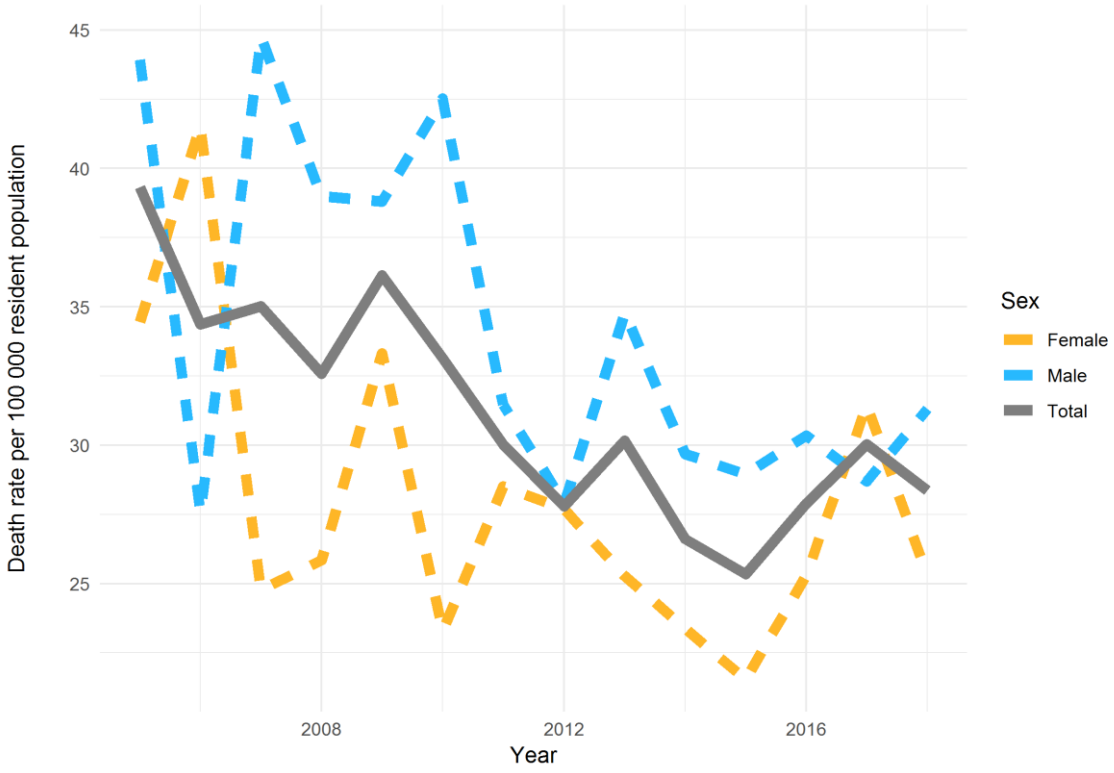

Figure 1: Death rate by year of death and sex for all children, South Australia 2005-2018

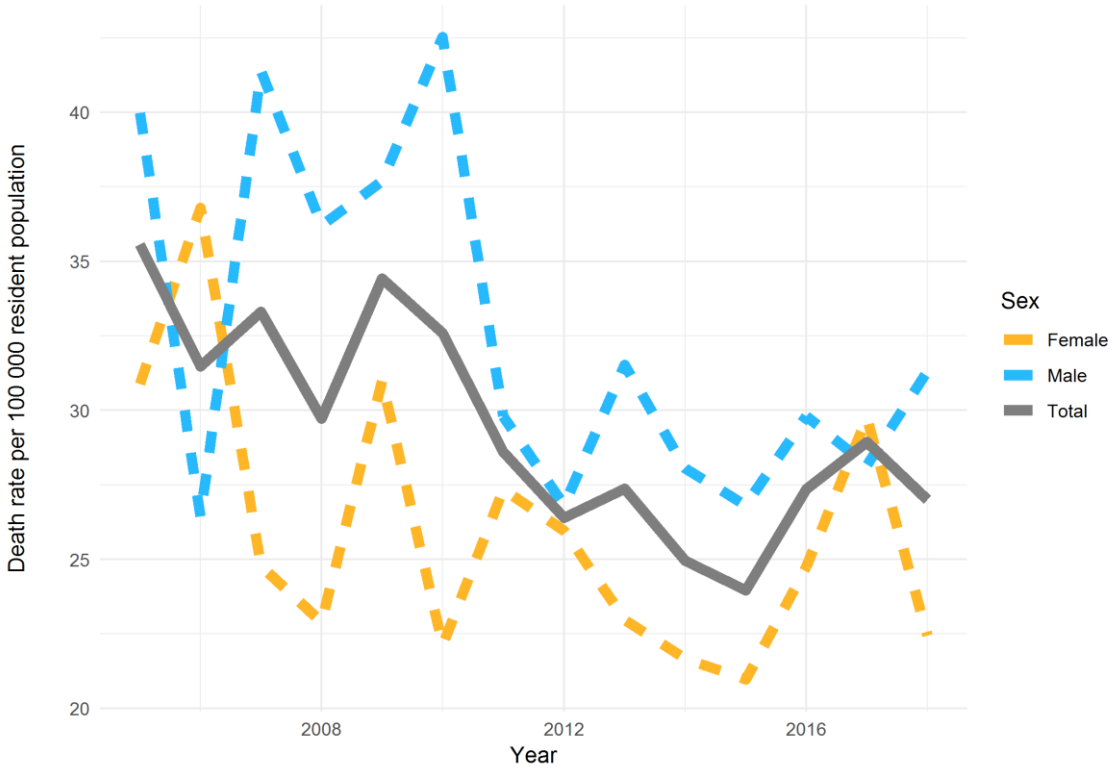

Figure 2: Death rate by year of death and sex for children who were usual residents, South Australia 2005-2018

1.2.1. Death rates by region

Important issues for service planning and delivery are highlighted when death rates and numbers of deaths are mapped against the South Australian Government's twelve administrative regions.

The highest rate of death for children is associated with living in the Far North region of the state. In contrast, the greatest number of deaths is recorded in the Northern Adelaide region. Services should be planned and delivered to take into account regions where the rate of death is highest, and regions where the greatest number of deaths occur.

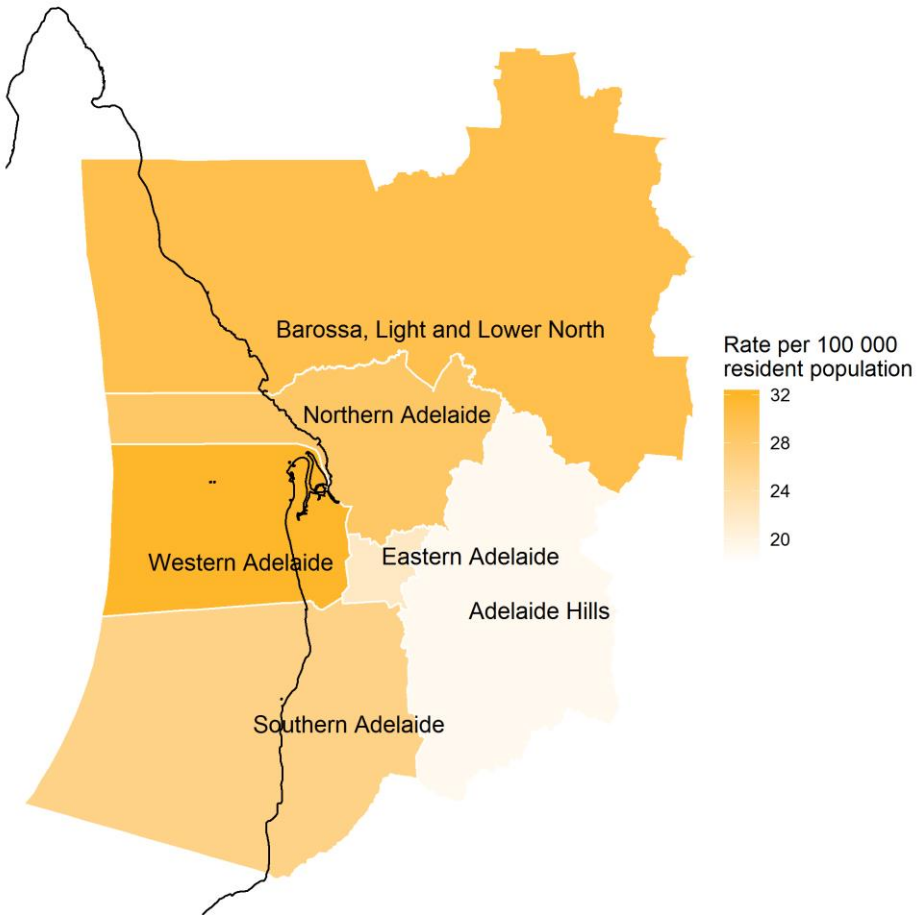

Figure 3: Death rate by region of metropolitan and inner rural South Australia for children who were usual residents, 2005-2018

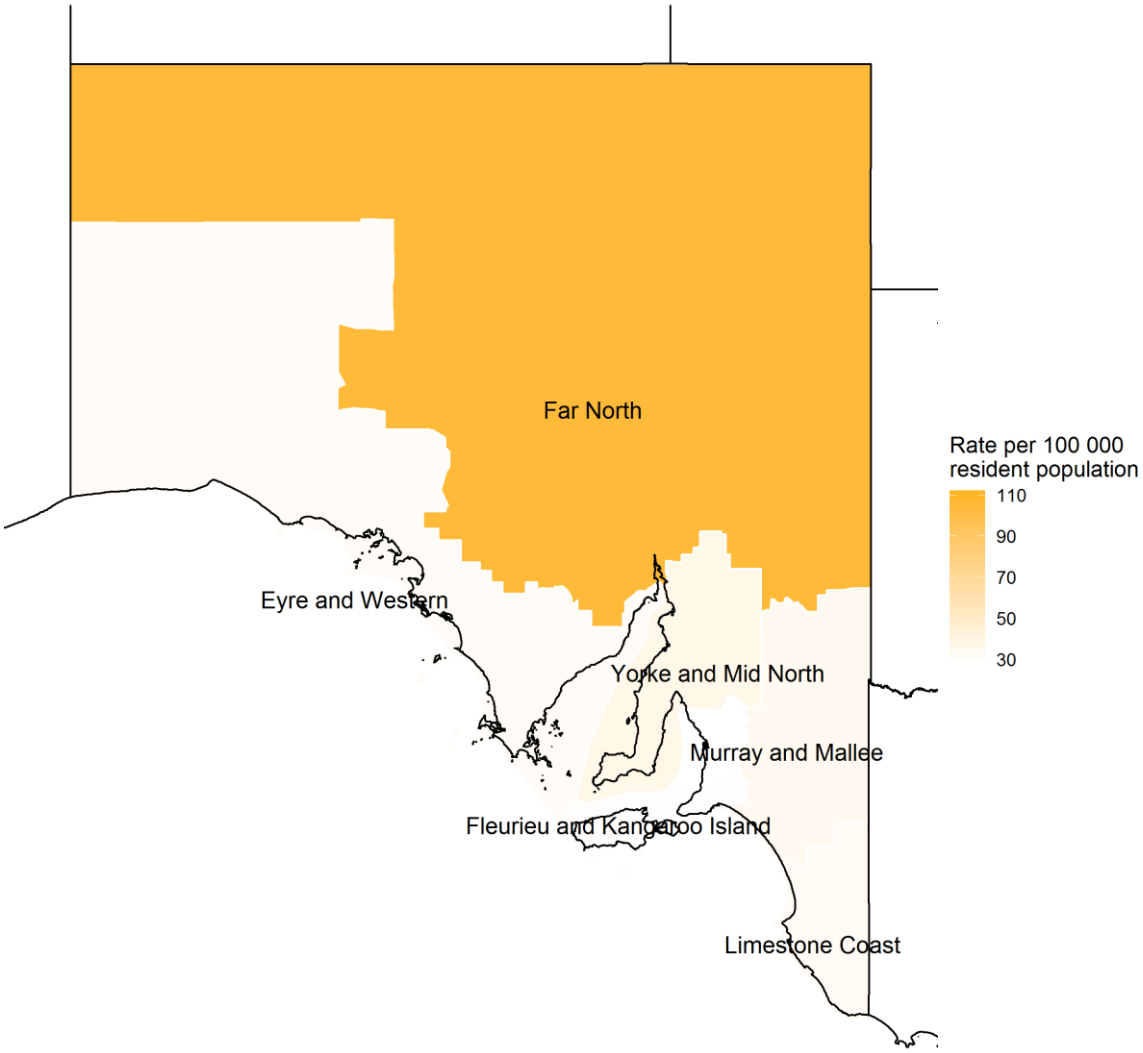

Figure 4: Death rate by outer rural region of South Australia for children who were usual residents, 2005-2018

1.2.2. Age and causes of death

Children die from many different causes, broadly categorised as:

- deaths from illness or disease, including conditions related to prematurity and birth, infections, genetic and other disorders, and cancer
- deaths from external causes – or injury-related causes – including deaths attributed to transport crashes, deliberate acts by another person, fire, drowning, suicide and accidents
- undetermined causes of death. No apparent cause can be found for these deaths. This category includes Sudden Infant Death Syndrome (SIDS).

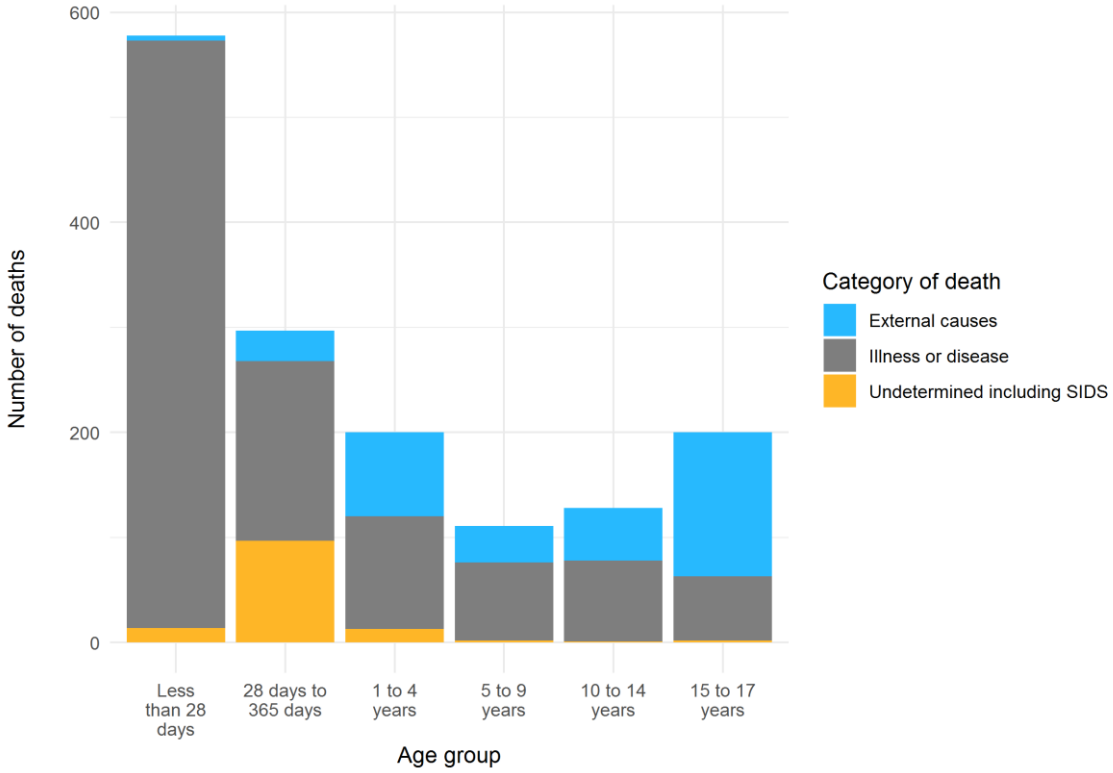

Figure 5: Number of deaths by age group and category of death for all children, South Australia 2005-2018

The leading causes of death for South Australia's children are those attributed to illness or disease, especially for very young infants. Older children are more likely to die from external causes, particularly transport crashes and by suicide.

1.2.3. Deaths of non-resident children

Eighty-nine of the 1552 children who died in South Australia between 2005 and 2018, were usually resident in another state, territory or country.

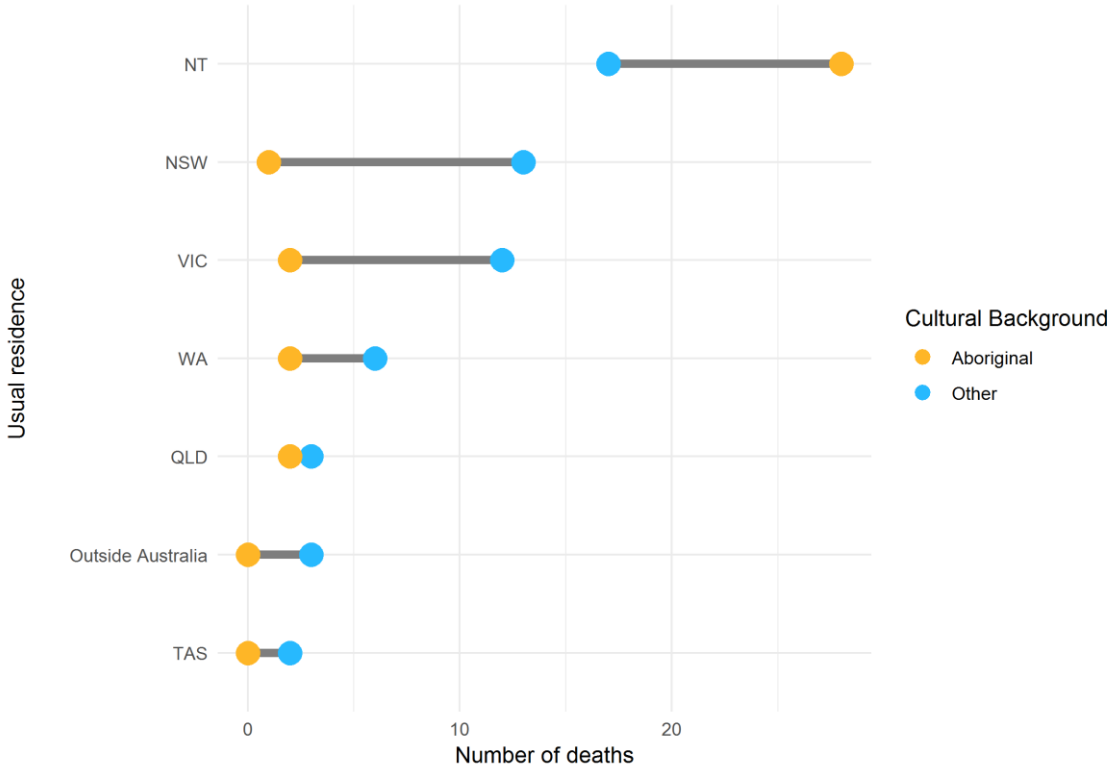

Figure 6: Number of deaths by state, territory or country of residence and cultural background, for children not usually resident in South Australia, 2005-2018

The highest number of non-resident children who died in South Australia between 2005 and 2018, were 45 children from the Northern Territory, 28 of whom were Aboriginal.

Many of these deaths occurring in South Australia reflect cross-border arrangements where seriously ill children are brought to Adelaide for treatment of complex medical conditions associated with extreme prematurity, infant and childhood illness, and various external causes.

1.2.4. Child death and socioeconomic disadvantage

More children die in areas of South Australia where there are greater levels of socioeconomic disadvantage[4]. The relationship between child deaths and socioeconomic disadvantage, across various categories of death, is shown in Figure 7. Deaths of all children who were resident in South Australia between 2005 and 2018, and for whom a cause of death is known, were included in this analysis. The following key points were highlighted by the analysis:

- between 2005 and 2018, a higher number of children died in areas of the state where there were greater levels of socioeconomic disadvantage
- there is a consistent pattern of low numbers of deaths in the 5 to14 years age group, with numbers peaking in the youngest (0-4 years) and oldest (15-17 years) age groups
- the increase in the number of deaths in those younger and older age groups is greater where levels of socioeconomic disadvantage are higher. There is a particularly high number of deaths in children under one year of age at higher levels of socioeconomic disadvantage.

When considering disadvantage and various categories of death:

- there is a strong association between higher levels of socioeconomic disadvantage and children dying from illness or disease (0-4 years age group) and in transport crashes (15-17 years age group)
- deaths caused by fire, drowning, and deaths resulting from the deliberate act of another person, all involved greater numbers of children from areas of higher socioeconomic disadvantage
- the distribution of deaths in those previous three categories also highlights the vulnerability of toddler and pre-school aged children; the greatest number of deaths occurring in the 1-4 years age group
- suicide deaths stand out as they indicate the least evident effect of socioeconomic disadvantage.

[4] *For information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 3.*

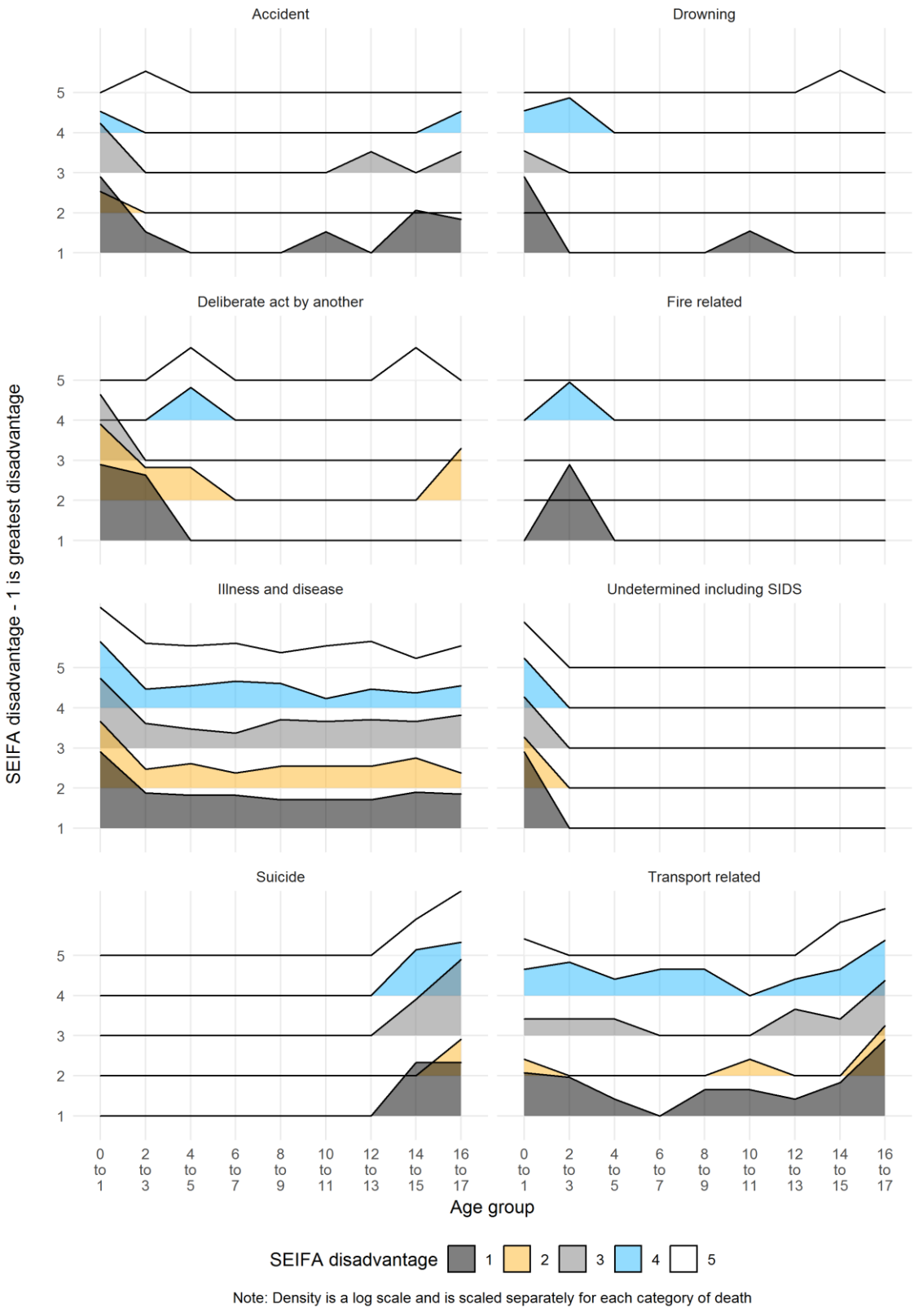

Figure 7: Number of deaths by age group and relative advantage and disadvantage SEIFA quintile, for children who had a definable SEIFA level in South Australia, 2005-2018

1.3. Child deaths and the child protection system

The Committee continues to review deaths of children where a child or their family has had contact with the Department for Child Protection (DCP)[5], to monitor the implementation of recommendations associated with these reviews, and to analyse the number and causes of deaths.

1.3.1. The number and causes of death for children who had contact with the child protection system

In the fourteen years from 2005 to 2018, 427 of the 1552 children who died (28%), or their families, had had contact with the child protection system in the three years prior to their deaths. Of these 427 children, 225 (53%) lived in the state's most disadvantaged areas[6].

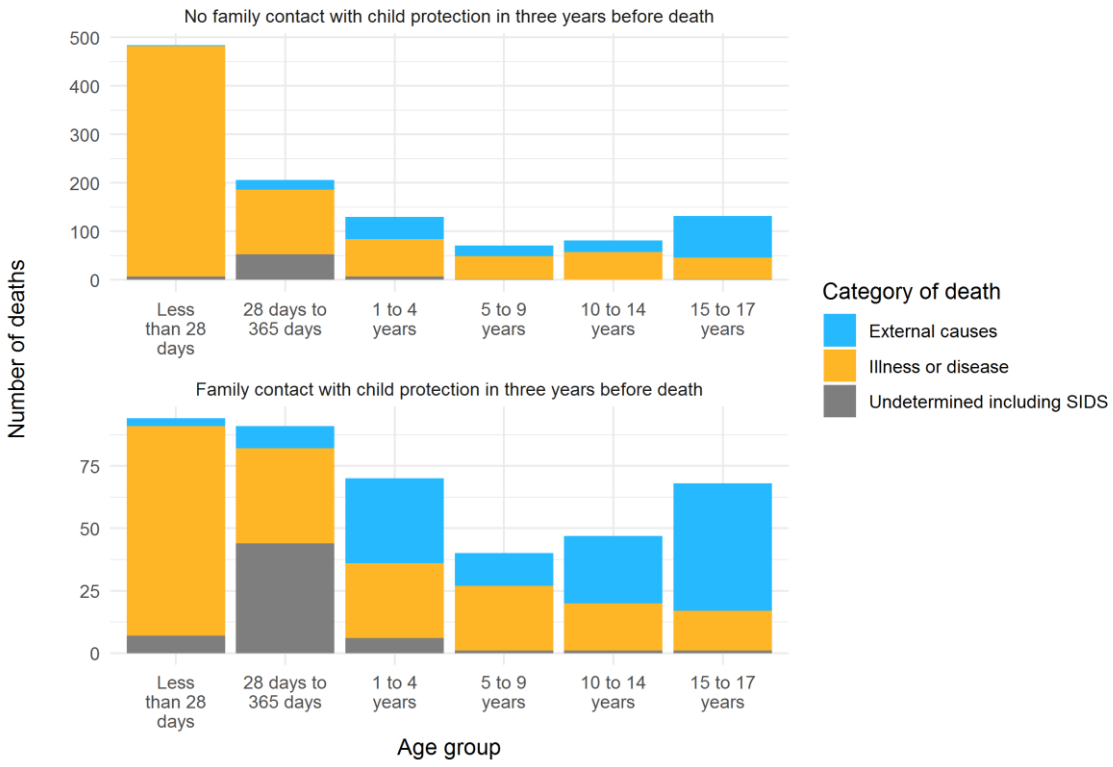

Figure 8: Number of deaths by age group, category of death and child protection contact status for all children, South Australia 2005-2018

[5] *The child or a member of their family must have had some form of contact with DCP or its predecessors, within three years of the incident resulting in their death.*
[6] *As represented by postcodes within the lowest relative disadvantage SEIFA quintile within South Australia. For more information on how socioeconomic disadvantage is defined and used in this Annual Report see Section 3.*

Notable in Figure 8, is the number of deaths of infants aged 28 days to one year, with a family history of contact with DCP. For this group, the leading cause of death is attributed to undetermined causes, including SIDS.

1.3.2. Priority areas for change to the child protection system

In its 2017-18 Annual Report[7], the Committee identified priority areas for change for the child protection system. Based on its work during the current reporting period the Committee:

- has ongoing concerns about the number of times a notification has been 'closed no action' in the case files it has read
- has recently made recommendations in relation to neglect and cumulative harm that:
    - emphasise the responsibility of DCP to be accountable to the government and the community of South Australia for the protection and safety of children
    - require DCP to monitor the number and assessment of notifications for children living in complex circumstances, in determining when and how to intervene (see Table 1: Recommendations for Case 999)
- continues to identify cases where improvements must be made to practices to protect the safety of infants at risk
- is yet to see any impact on practice regarding young people who have been in State care, and will continue to undertake in-depth reviews focusing on the infants of vulnerable young parents (see Section 1.3.3)
- has provided comment on DCP's proposed Clinical Governance Framework in which it:
    - expressed concern about DCP's ability to monitor the strategies set out in the Framework, where much emphasis is placed on the analysis of data collected from many different sources
    - considers that the adoption of a health-focused paradigm to govern child protection practice, presents considerable challenges for implementation

[7] *http://www.cdsirc.sa.gov.au/wp-content/uploads/2018/11/CDSIRC-2017-18-Annual-Report1.pdf*

    - expressed concern that there is no clear distinction made between a governance framework, a practice framework, practice guidelines and service delivery, and how each of these will be evaluated
- has provided comment on the development of the terms of reference for the Adverse Events Panel and about adverse events reviews, and:
    - is still concerned that there is no independent Chair for the Panel
    - recommended the need to set time frames for the review of an adverse event, and consideration of a hierarchy of differential responses according to the severity of the event and the level of DCP's involvement with the child. Using this hierarchy, review of events involving children living in a DCP residential care facility, who are in State care, would be the highest priority for review, within a time frame that sees effective and timely action
    - understands that training in 'root cause analysis' has been conducted as a means of guiding the review of adverse events, but is yet to see quality and consistency in the review reports it has received
- is concerned that DCP's processes for assessing and responding to 'care concerns' has been under review for at least 18 months.

The Committee has used the following sources of information to monitor progress in these priority areas:

- critical review of any contact with the child protection system for every child who has died in South Australia (36 cases in 2018)
- quarterly meetings with DCP senior executives
- presentations from DCP senior executives at Committee meetings
- review of draft child protection policies
- presentations to, and discussions with, DCP staff about issues arising from reviews of child deaths
- meeting with the Minister for Child Protection
- in-depth reviews of child deaths that identify child protection issues
- monitoring the number of child deaths where the child or family had contact with the child protection system

- monitoring the number of deaths where the child's parent(s) had at some time been in the care of the State.

1.3.3. Monitoring system improvements in the child protection system

Children in State care[8]

For the purposes of review, the Committee identifies children who have died, and who have ever been in the care of the State, or in care in another jurisdiction. The Committee has identified 25 children who died between 2005 and 2018, who meet these criteria. Fifteen (60%) of these 25 children were Aboriginal. In addition, 13 (50%) of these 25 were children with disabilities.

In the current reporting period, the Committee reviewed the death of a young child with disabilities who, at the time of their death, was in State care. The review concluded that the quality of care for this young child fulfilled the criteria for the best possible outcomes for such children (see Section 1.5.2).

The Committee has also identified 28 infants or children who died, where one or both of their parents had, at some time during their lives, been in State care. Fifteen parents of these infants or children, have been the subject of two previous in-depth reviews[9]. The mother of the child who was the subject of the review summarised in Section 1.5.2, was herself in the care of the State as a young person. This young mother experienced complex and challenging life circumstances that were further compounded by the loss of a child. The circumstances of her life provided further evidence of poor outcomes for parents who have been in State care, and the need for the child protection system to continue the care of young people beyond the age of 18 years.

Recommendations for service improvements identified by the Committee in its two previous reviews of children who died and whose parents had also been in State care, are:

- improved communication between states and territories to ensure the timely exchange of information, given that these parent(s) can be highly mobile

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[8] *'Children in State care' or 'in the care of the State' includes those children who were under the guardianship of the Minister, or after legislative change in 2017, under the guardianship of the Chief Executive, Department for Child Protection.*

[9] *Further details about these reviews can be found in the Committee's annual reports of 2014-15 and 2016-17. http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2014-15_cdsirc_annual_report.pdf http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/11/2016-17-CDSIRC-Annual-Report.pdf*

- recognising and responding to the long-term consequences of trauma, including the provision of therapeutic care for children in State care
- transition-from-care plans for all young people who have been in State care, and ensuring the timely and appropriate extension of support for these young people up to age 25
- support for young parents who have a history of State care, that extends into the early years of their child's life.

A recent update about these issues, provided by the Chief Executive DCP, stated that DCP is now ensuring transition planning is integrated into case planning for children and young people in State care, and that DCP has initiated several programs designed to provide care beyond the age of 18 for these young people (eg, Stability and Family-based Care, Over 18 Education Initiative, Post-care support – Relationships Australia).

Progress with training in the SA Safe Infant Sleeping Standards

In its 2017-18 Annual Report[10], the Committee reported on the unsafe sleeping factors present in the sudden and unexpected deaths of infants who had been placed to sleep. Nearly 50% of these infants or their families had previous contact with DCP. In that report, the Committee advocated for prevention measures to address this statistic, including training in the SA Safe Infant Sleeping standards for all workers involved in the provision of care to infants.

At the time of writing, DCP has advised that it is at the point of engaging a provider to deliver child safety training.

Progress with the analysis of data provided by the child protection system

In 2017-18, the Committee commenced analysis of large data sets provided by DCP. Revision of the protocol between the Committee and DCP that defines the terms for the release of this data, delayed further work in this area in 2018-19.

[10] *http://www.cdsirc.sa.gov.au/wp-content/uploads/2018/11/CDSIRC-2017-18-Annual-Report1.pdf*

1.4. Deaths of Aboriginal children

1.4.1. The number and causes of Aboriginal child deaths

During the period 2005 to 2018, Aboriginal children constituted only 3% of the child population of South Australia, but they accounted for 12% of child deaths. The rate of death for all Aboriginal children who died in South Australia was 126 deaths per 100 000. For Aboriginal children whose usual place of residence was in South Australia, the death rate was 103 deaths per 100 000 over the same period. This difference in rates reflects the number of children with complex medical conditions who were retrieved from other states or territories for treatment in South Australian hospitals (see Section 1.2.3). The rate of death for non-Aboriginal children was 28 deaths per 100 000. The rate of death for non-Aboriginal children usually resident in South Australia was 26 deaths per 100 000.

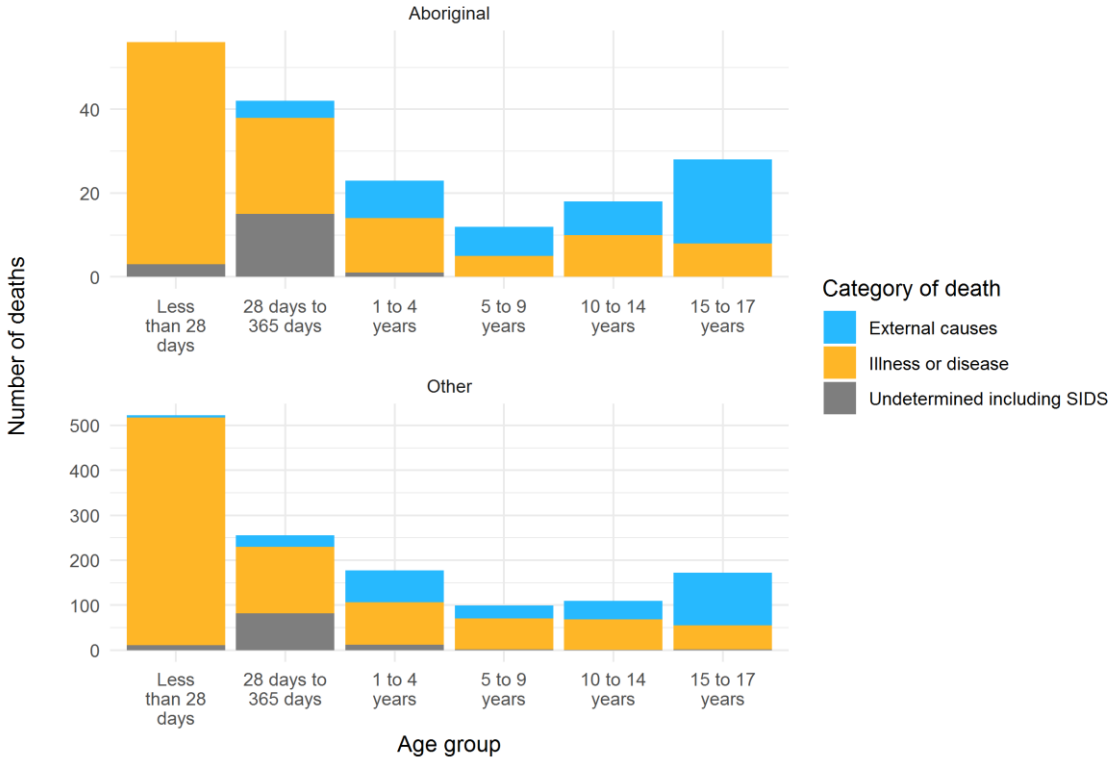

Figure 9: Number of deaths by category of death and cultural background for all children, South Australia 2005-2018

The distribution of Aboriginal child deaths across age groups is similar to the distribution of deaths for non-Aboriginal children, although a greater proportion of Aboriginal children are dying in the first year of life compared to non-Aboriginal children.

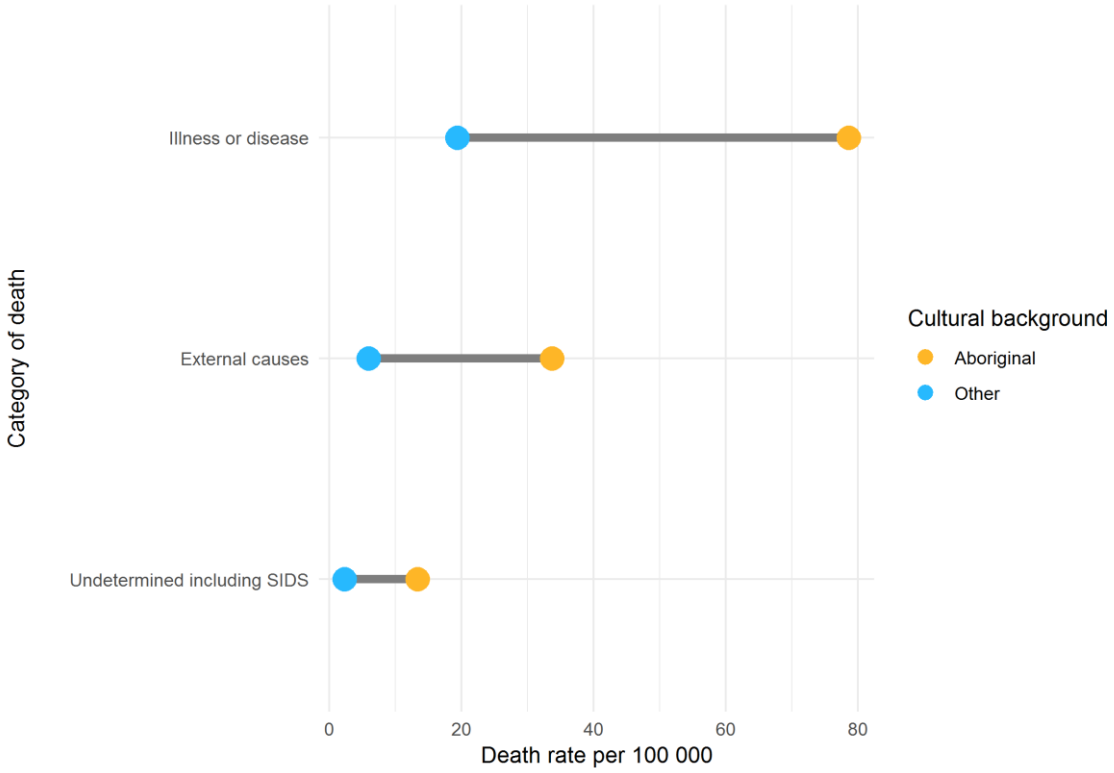

Figure 10: Death rate, by category of death and cultural background for all children, South Australia 2005-2018

Across all three categories of death, the death rate is higher for Aboriginal children, than for non-Aboriginal children. It is particularly noticeable that the death rate due to illness or disease for Aboriginal children, is more than four times the rate for non-Aboriginal children. This difference in rates suggests that prevention efforts for Aboriginal children should continue to focus on factors that address the fundamental determinants of health.

1.4.2. Review of the death of an Aboriginal child

Case summary – an Aboriginal child who had extensive contact with the child protection system

The child who was the subject of this review, was the eldest of three children born to a family living in rural South Australia. He had an Aboriginal cultural background, and had been in the care of various family members throughout his life.

Agencies noted that this child lived in a ‘family in crisis’, and within an ‘unsafe environment’. He and his siblings were not consistently cared for, supported, supervised nor protected from harm, in spite of over 50 notifications to the child protection system.

The child died after being hit by a vehicle. The incident was witnessed by his younger siblings. His siblings were thereafter placed in the care of the State, and while their care became more consistent and protective, their emotional and behavioural responses continued to reflect their grief and years of deprivation.

Committee Findings

For a decade, these children were known to the child protection system. They grew up in a number of care environments, all of which were characterised by violence, drug and alcohol abuse, severe neglect, lack of supervision, and abuse. The children roamed at night alone, engaged in substance abuse and risky behaviours. They were left with others, both known and unknown to them, and found places to stay. They had low school attendance, compromised learning ability, and committed minor offences. They did not have the benefit of growing up safely, and nothing changed until the life of one child ended.

These children's lives are a result, in part, of the complexities of their parents' lives. The general level of disadvantage and trauma experienced by generations of Aboriginal families, their distrust of human service agencies, and the burden of chronic health problems - including physical and mental health issues, and the effects of alcohol and drug abuse - have affected parents' capacity to provide adequately for themselves and their families.

Knowing that they were not provided with the level of care and safety that they required, DCP was responsible for ensuring their protection. Child protection records indicated that notifications were too often 'closed no action', marked 'no further action taken' or referred to other agencies with 'a view to case closure'. There was no oversight nor management of this child's case.

The Committee has observed in other cases that the assistance and support DCP offers to carers and children after a tragic event is significant. It must be supposed that some of this effort made earlier might have spared the children and their family this tragic outcome.

Since the submission of this review to relevant Ministers in late July 2019, the following responses to the associated recommendations have been received.

Table 1: Recommendations and responses from a review into the death of an Aboriginal child

Recommendations and responses
Recommendation 1
That the Minister for Child Protection ensures that the Department for Child Protection (DCP) acts in accordance with the understanding that in families where parental ability and responsibility is compromised to the extent that children are unsafe and not developing optimally, the staff of that department are responsible and accountable to the government and the community of South Australia, for the protection and safety of those children.
Response, Chief Executive, Department for Child Protection
The letter of response did not address this recommendation.
Recommendation 2
That the Minister for Child Protection ensures that in recognising that the number of notifications, as well as the severity of a child's circumstances, are factors in cumulative harm, that DCP monitor the number and assessment of notifications for children living in complex circumstances, in determining when and how to intervene.
Response, Chief Executive, Department for Child Protection
There is now a statutory obligation for DCP, when assessing the likelihood that a child or young person will suffer harm, to not only give regard to the current circumstances of the child or young person's care, but to the history of their care and the cumulative effect this may have had.
Recommendation 3
That the Minister for Child Protection ensures that the DCP critically review all cases where a child who has been the subject of its consideration/actions has died or suffered serious injury. Further, that DCP institute a critical review process with key agencies involved in the child's/family's life when a child has died or suffered serious injury.
Response, Chief Executive, Department for Child Protection
In 2019, DCP commenced a more formal approach to quality and clinical governance via implementation of the Clinical Governance Framework. The department will use this Framework in conjunction with the critical review of cases where a child or young person subject to DCP consideration has died or suffered serious injury.
Recommendation 4
That the Minister for Human Services ensures that the issues raised in this review, inform the planning and co-design of the Department of Human Services' Safer Family Programs' (DHS – SFP) contact and work with families experiencing complexity and vulnerability.
Response, Minister for Human Services
The de-identified case summary has been provided to the Director, Early Intervention Research Directorate for consideration as part of the co-design process currently being undertaken. Copies are also informing the practice development work in train across Safer Family Services (SFS).
Recommendation 5
That the Minister for Child Protection and the Minister for Human Services ensure that in families where children are the subject of notifications regarding abuse and/or neglect, that the DCP and the DHS – SFP work collaboratively to ensure the co-ordinated involvement of required services for the safety and protection of children, and that they continue to actively manage the cases of such families and children until improved and sustainable outcomes are achieved.
Response, Chief Executive, Department for Child Protection
The review of these cases highlights the importance of key and fundamental changes that have occurred as a result of changes in practice informed by Legislation. Information sharing between state authorities is now assured through the operation of section 152 of the Act. This, and the ability to refer matters to one or more state authorities pursuant to section 33, will significantly improve outcomes for children.

Recommendation 6

That the Minister for Child Protection and the Minister for Human Services ensure that the DCP allow the closure of a case, and DHS - SFP cease involvement in a case - only when sustained improved outcomes in family functionality, and the child's health and behaviour, and education, are evident.

Response, Chief Executive, Department for Child Protection

The letter of response did not address this recommendation.

Response to 5 and 6, Minister for Human Services

The SFS' suite of programs work proactively with the Department for Child Protection (DCP) to address identified factors contributing to poor family functioning where risk to children is present. As part of therapeutic interventions undertaken by the SFS (Strong Start, Child Wellbeing, and Family Practitioners), and where appropriate, information is routinely shared with DCP colleagues.

In addition, the Child and Family Assessment and Referral Networks (CFARN) work closely and proactively with local DCP offices in relation to referrals received. The Local Partners Group in each CFARN region provide high level consultation and information sharing to support system coordination where multi-agency responses to families are needed.

Recommendation 7

That the Minister for Education ensures that the Department for Education's Attendance Program (implementation activities and staff development) incorporates the actions required by school staff in circumstances of chronic absenteeism and significant social risk factors where parental ability and responsibility are compromised to the extent that children are unsafe.

Response, Minister for Education

The department's Attendance Matters in South Australian preschools and schools document, released in 2018, reinforces student absences can indicate varying degrees of risk for students in relation to their learning and wellbeing. Thresholds have been established which identify students and provide a way for schools to be alerted to the need to assess a child's circumstances and the degree of risk the child may be exposed to by their non-attendance. The thresholds are:

- *habitual non-attendance: where a student has 5 or more absences per term for any reason.*
- *chronic non-attendance: where a student is absent for 10 days or more per term for any reason.*

There are procedures and technology available to schools which support them to identify students. Schools are required to:

- *implement an attendance improvement plan, developed in collaboration with school communities, with clearly stated targets and strategies*
- *monitor unsatisfactory participation or unexplained absences including frequent absences due to illness or family reasons*
- *increase the level of intervention (which includes phone calls, home visits) when a student has been identified as meeting the above thresholds*
- *ensure students who meet these thresholds are followed up and monitored in order to assess the need for further intervention at the school level or a referral to the local Student Support Services*
- *make mandatory notifications to the Child Abuse Report Line (CARL), including in relation to chronic non-attendance.*

Recommendation 8

That the Minister for Education ensures that the actions identified in the Department for Education's current suspension and exclusion policy, are monitored to ensure that suspending children where there are high risk factors and significant child safety issues, is done with additional support for children and their families and escalation to child protection services.

Response, Minister for Education

The department's Behaviour Support Policy provides the framework for all behaviour responses including suspensions and exclusions and requires that departmental staff:

- *support the participation of all students, taking special measures to support the inclusion of children and young people who are at higher risk of exclusionary responses to their behaviours.*

- *apply exclusionary responses as a strategy of last resort.*
- *work with parents, caregivers, families, service providers and the community to support children affected by behaviours of concern.*
- *support children and young people to be physically and psychologically safe.*

The department's Procedures for Suspension, Exclusion and Expulsion from Attendance at School include requirements and practice considerations to ensure that the suspension and exclusion of children at risk is done with additional support for children and their families.

Behaviour Support Coaches involved in exclusions provide additional oversight and monitoring of suspension and exclusion processes and student wellbeing. Student wellbeing leaders and pastoral care workers work as part of the education team to monitor and respond to student wellbeing needs.

In the review of a group of Aboriginal children completed in 2012, the Committee made recommendations in relation to the children's cultural background, particularly that service providers reinforce existing good practice standards. In this current review, the Committee reiterates these points, recommending that:

Recommendation 9

All agencies apply the same standard of care for Aboriginal children as for non-Aboriginal children.

Response, Chief Executive, Department for Child Protection

The letter of response did not address this recommendation.

Recommendation 10

Intervention occurs in culturally appropriate ways which ensure that the consideration of risk and safety issues for Aboriginal children is no different to that given to non-Aboriginal children.

Response, Chief Executive, Department for Child Protection

The letter of response did not address this recommendation.

Response to 9 and 10, Minister for Human Services

Each of the therapeutic service streams within the SFS ensures cultural considerations are a key part of assessment and intervention.

Recommendation 11

All agencies build workforce capacity to provide culturally responsive services.

Response, Chief Executive, Department for Child Protection

The letter of response did not address this recommendation.

Recommendation 12

All agencies have effective employment strategies in place to support the employment, supervision and professional development of Aboriginal workers.

Response, Chief Executive, Department for Child Protection

The letter of response did not address this recommendation

Response to 11 and 12, Minister for Human Services

As part of recruitment processes for the SFS, non-Aboriginal applicants (at all levels) are assessed for their knowledge and understanding of Aboriginal history and context, as well as their demonstrated experience working effectively with Aboriginal families. Selection panels include Aboriginal staff and external partners as key participants in recruiting appropriately qualified and experienced staff.

Child Wellbeing, Strong Start and CFARN each have designated Aboriginal practitioners. There are also Aboriginal staff employed in non-designated positions such as administration and social work roles.

Aboriginal staff across the SFS are supported in a variety of ways, for example; regional networking meetings, regular and timely clinical supervision, and co-working cases where appropriate. Retention of Aboriginal staff working across the program areas has been high, which may be attributable to ensuring non-Aboriginal staff have appropriate cultural understanding, and Aboriginal staff are supported in their work.

1.4.3. Monitoring system improvements for Aboriginal children

The Committee's 2016-17 Annual Report[11] summarised a review of two young Aboriginal mothers whose infants had died. The review highlighted the need for Aboriginal children and young people to have a strong and influential advocate who could work actively to ensure that they had the opportunity for a full and healthy life.

The Committee recommended that the South Australian Government appoint a (Deputy) Commissioner for Aboriginal Children and Young People. In its 2017-18 Annual Report[12], the Committee noted that the legislation was being finalised to establish this position and in October 2018, the inaugural South Australian Commissioner for Aboriginal Children and Young People was appointed.

The Committee is encouraged by this appointment but holds the same concerns expressed in the 2017-18 Annual Report, regarding:

- the scope of legislative powers provided to the Commissioner for Aboriginal Children and Young People and the interface between this Commissioner and the (already established) Commissioner for Children and Young People; and
- the resources available for the establishment and effective operation of the office of the Commissioner for Aboriginal Children and Young People.

In the Committee's view, these issues continue to require consideration with respect to the Commissioner's role as a strong and influential advocate for Aboriginal children and young people.

[11] *http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/11/2016-17-CDSIRC-Annual-Report.pdf*
[12] *http://www.cdsirc.sa.gov.au/wp-content/uploads/2018/11/CDSIRC-2017-18-Annual-Report1.pdf*

1.5. Deaths of children with disability

Families caring for children with a disability face significant challenges in accessing services and support for their children. Information about the deaths of all children in South Australia is reviewed by the Committee in order to determine whether a child's daily activities had been significantly limited by disability, and to explore connections between the disability and the child's subsequent death.

During the period 2005 to 2018, 337 of the 1552 children who died (22%), were assigned disability status by the Committee[13].

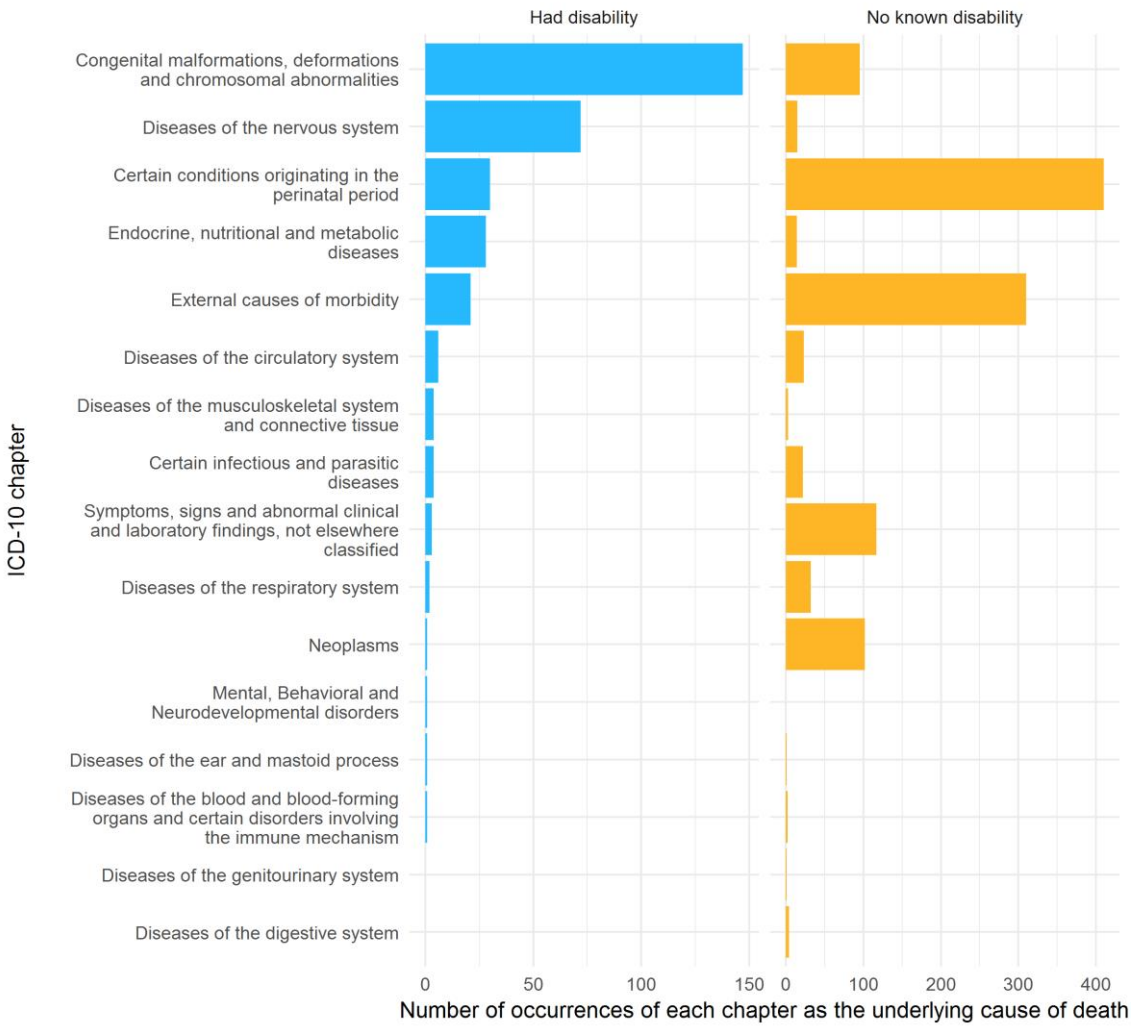

Figure 11: Number of occurrences of ICD-10 chapters, by disability status, for all children, South Australia 2005-2018

[13] *See Section 3.6 for the Committee's definition of disability status.*

1.5.1. The number and causes of death for children with disability

The causes of death for children whose daily lives were impacted by a known disability, when compared with children with no known disability:

- are more commonly associated with congenital and chromosomal abnormalities
- more frequently include diseases of the nervous system (this includes cerebral palsy and epilepsy), and diseases of the respiratory system. Once children aged 1-17 years are identified as having a disability, the Committee can assign one or more disability types. Sixteen percent of children had more than one type of disability.

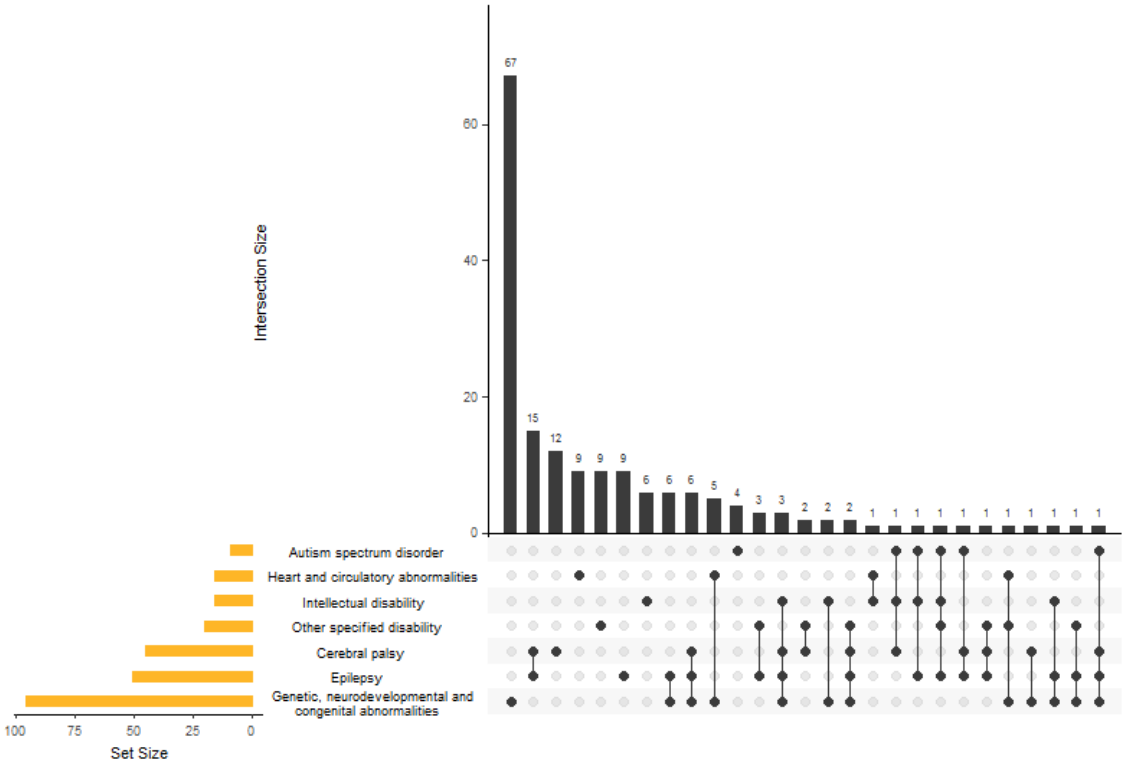

Figure 12: Number of occurrences of disability types, by number of occurrences of each combination of disability types, for children with a disability status aged 1-17 years, South Australia 2005-2018

Figure 12 shows, for example, that of the nine children who died who had been diagnosed with autism spectrum disorder (ASD), four had no other diagnoses. Of the other five: one had been diagnosed with an intellectual disability and cerebral palsy; one had been diagnosed with ASD, an intellectual disability, epilepsy and another specified disability; one had been diagnosed with ASD, cerebral palsy and epilepsy;

and another had been diagnosed with ASD, cerebral palsy, epilepsy and a genetic, neurodevelopmental or congenital abnormality.

In terms of service provision, it is notable that a higher number of children died who had both epilepsy and cerebral palsy (29) compared to the number of deaths of children with epilepsy alone or in conjunction with another disability (22).

1.5.2. Reviewing the deaths of children with disability

Case summary - a child with disabilities who was in State care

This child was born with a genetic disorder. Soon after birth it was understood that her life would be limited by the consequences of this disorder. Her health was fragile and she was fully dependent on carers for all her needs. Very soon after birth, she was placed in the care of the State, as her mother was unable to care for her. During her short life she spent time in hospital, with foster carers, and in commercial care. In the seven months before her death, which resulted from consequences of her fragile health, she was living with two other children who were also in State care, and who also had complex care needs. These children's care was provided by a 24 hour roster of registered nurses. The care provided to this child was consistent and personalised with an emphasis on activities that the child appeared to enjoy.

The child's mother had also been in the care of the State, and following her 18th birthday, she was the subject of a Guardianship Order and resided in supported accommodation. She needed assistance with the tasks of daily living including personal hygiene, cooking, shopping, attending appointments, and compliance with medical advice.

The mother was supported by various services throughout her pregnancy, including disability and child protection. Following the child's birth, the child protection system provided the mother with regular access visits, including during the child's final period of hospitalisation. To the extent possible, the mother was included in the child's End-of-Life and funeral plans, and was supported after the death of her child.

Committee findings

In the Committee's view, systems worked as well as they could to provide this child with a good quality of life. During her final period of hospitalisation, there was strong evidence of responsive care, and collaboration between medical, complex nursing and

palliative care specialists. Due consideration was given to the quality, rather than the extension, of her life. The End-of-Life planning was commendable.

This case meets the criteria the Committee has previously proposed in order to achieve good outcomes for children with disability:

- the child's needs, not those of the service system, are central to planning
- a whole-of-life approach is taken when surgical and other medical interventions are being proposed
- there is a minimal number of placements and the child is cared for by committed carers with appropriate training
- connections are maintained with the child's birth family
- palliative and End-of-Life planning are in place before 'needed' and this planning is considerate of carers, parents and staff of support agencies.

However, the review provided further evidence of poor outcomes for children whose parents have themselves lived in State care, and the need for the child protection system to continue to care for young people beyond the age of 18 years. (Section 1.3.3)

Case summary - a child with disabilities receiving services from multiple agencies

This young person was diagnosed with a genetic disorder that necessitated several corrective surgeries when he was young, and from an early age, ongoing speech, occupational and physical therapies. Regular review with paediatricians and pain specialists to manage the increasing pain associated with this disorder were necessary. This disorder did not affect his intellectual capacities.

In his early school years, this young person began to experience mental and emotional health problems. Ongoing support was provided by a mental health service but there appeared to be little change in his mental health over the next two years. School attendance problems also emerged during these years, and in the two years prior to his death, he was absent for over half of each school year.

The child protection system received notifications about this family but none were deemed to require investigation.

The young person's parents were diligent in their efforts to support him, but their parenting capacity was limited by their own physical and mental health problems.

The young person died of consequences associated with a drug overdose. The Committee determined the death to be accidental, however, the quantities of prescribed medications found in the household following this young person's death raised questions about the oversight of prescribing, and safe storage, of such medications.

Committee findings

This young person experienced significant challenges throughout his life. A number of services worked diligently to try to improve his quality of life. The Committee accepts that a child with mental, physical, emotional and family problems presents challenges for service agencies. This young person and his family required integrated and co-ordinated service delivery. The Committee could find evidence of only one 'case management' meeting that involved more than one service provider.

In the Committee's view, the young person's complex needs, in the context of his family circumstances, should have triggered an approach such as 'team around the child' (TAC)[14]. The purpose of a TAC approach is to prevent the fragmentation and chaos that families often experience when the people working with the child work separately from one other. A TAC approach aims to:

- see all aspects of the child including their personality, strengths, weaknesses, preferences and genetic inheritance, as parts of a unique system
- see the child within the systems of close and wider family, and community
- see each child's impairments and disabilities as 'interconnected parts of an emergent, unique and multifaceted condition'[15]
- bring together the people closely involved with the child
- integrate, as appropriate, separate treatments, therapies and educational programs into a single approach.

If health, education, and mental health agencies had adopted a TAC approach, it would have prompted:

- development and implementation of a long-term case plan that: recognised the child as the primary client and central to that plan; reflected his voice and views;

[14] *http://www.tacinterconnections.com/index.php/tacmodel*
[15] *http://www.tacinterconnections.com/index.php/tacmodel*

and integrated the services providing care to him and his family with case management responsibility by one agency

- critical overview of the family's functioning, especially the capacity of the child's parents to provide for his mental health and emotional needs
- critical reflection about the effectiveness of the services being delivered to the child
- oversight and management of the medication use of all family members, and critical examination of the family's prescribing history, and use of licit and illicit drugs.

Since the submission of this review to relevant Ministers in late July 2019, the following responses to the associated recommendations have been received.

Table 2: Recommendations and responses from a review into the death of a child with disabilities receiving services from multiples agencies

Recommendations and responses
Recommendation 1 A multi-agency 'team-around-the-child' approach that ensures integrated service provision for children with complex needs that becomes the responsibility of all agencies working with that child and their family. This approach should be adopted for children with complex needs by the Department of Human Services' Child and Family Intensive Support System. The Department of Human Services is responsible for the design and implementation of this system.
Response from the Minister for Human Services *The department considers the team around the child (TAC) as an appropriate approach to support children with families with complex needs requiring an interagency response. Child Wellbeing and CFARN identify the TAC as an evidence-informed approach in their respective models of practice.*
Recommendation 2 The Department for Health and Wellbeing (including CAMHS), the Department for Child Protection and the Department for Education, through their involvement in the co-design of the Child and Family Intensive Support System, should support the adoption of the TAC approach for children with complex needs. Such a process should identify these children, assess their needs and determine which agency will lead the TAC approach and agree clear roles and responsibilities for the other agencies involved. That lead agency should be responsible for monitoring the effectiveness of the services being provided. The signs of these complex needs should include: rates of absenteeism – including an increase in rates of absenteeism that is not explained; involvement of the child/family with mental health services such as CAMHS or headspace; involvement of the child protection system; the child's physical, emotional and intellectual disabilities.
Response from the Minister for Education *The department considers the team around the child (TAC) as an appropriate approach to support children and families with complex needs requiring an interagency response. Student Support Services identify the TAC as an evidence informed approach in their model of care and it is used by the department's complex needs team. The department supports a multi-agency TAC and will work with the Department of Human Services as recommended.*

The department's 'Attendance Matters in South Australian preschools and schools' document released in 2018 reinforces student absences can indicate varying degrees of risk for students in relation to their learning and wellbeing.

Schools provide increasing levels of intervention and monitoring when patterns of increasing non-attendance emerge. In cases of complex and ongoing chronic non-attendance, Student Support Services provide intensive intervention and support for the student, their family and the school in collaboration with other agencies. This includes collaborative work with child wellbeing practitioners and the Department for Child Protection.

Response from Minister for Human Services

The Department for Education's 'Attendance Matters in South Australian preschools and schools' document released in 2018, reinforces student absences can indicate varying degrees of risk for students in relation to their learning and wellbeing.

In cases of complex and ongoing chronic non-attendance, the Department for Education's Student Support Services provide intensive intervention for the student, their family and the school in partnership with other agencies. This includes collaborative work with Child Wellbeing and CFARN.

Recommendation 3

When the needs of such children are being evaluated, the potential benefits of school attendance should be assessed. In rare cases, school may not be the most appropriate learning environment for that child.

Response from the Minister for Education

I am advised the department is a member of interagency committees, including the interagency therapeutic needs panel and the complex care review committee. These committees aim to determine therapeutic interventions and access to appropriate services, including educational requirements. The department convenes a significant incident improvement group which identifies and plans appropriately for children with complex high risk needs in schools. Within these forums the department considers the most appropriate environment for the student, which may involve school with additional supports or alternative pathways and settings.

Recommendation 4

The Quality and Practice Directorate, Department for Child Protection, lead a review of the circumstances surrounding the death of this child, and the evaluation of risk to his siblings following his death. The review should identify actions that could have been taken. The findings from the review should be used to inform the development of current practice-related polices and processes. Other agencies which should participate in this review include the Department for Education and SA Health.

This review should also consider the processes in place through which information is exchanged with SA Police with regard to the management of risks to surviving children.

Response from the Chief Executive, Department for Child Protection

In 2019, DCP commenced a more formal approach to quality and clinical governance via implementation of the Clinical Governance Framework. The department will use this Framework in conjunction with the critical review of cases where a child or young person subject to DCP consideration has died or suffered serious injury.

With regard to the recommendations pertaining to the risk to surviving siblings in one of the cases, I can inform you that work has commenced to examine changes to the processes through which information is exchanged with South Australia Police.

Response from the Minister for Education

The department is committed to participating in the review of the circumstances surrounding the death of this child.

Response from Minister for Human Services

The department is committed to participating in the review of the circumstances surrounding the death of this child.

1.5.3. Monitoring system improvements for children with disability

Children with disabilities, DCP involvement and the National Disability Insurance Scheme (NDIS)

The Committee has commented in previous reports about its concerns for very vulnerable children and the acquisition and provision of services through the NDIS. The Department for Child Protection now has a unit dedicated to supporting children with disabilities who are under the guardianship of the Chief Executive. The Committee views this as a positive step towards ensuring that these very vulnerable children, often with high and complex needs, have the best chance of receiving the services they need through the NDIS.

Children with high and complex needs and the TAC approach

Through its review of child deaths, the Committee will seek to monitor the implementation and use of the TAC approach by the Department for Education and the Department of Human Services. It will also seek an update from both departments on the progress of their work in this area, in six months' time.

1.6. Infant mortality

Of the 1552 children who died in South Australia between 2005 and 2018, 888 (57%) were children under one year of age.

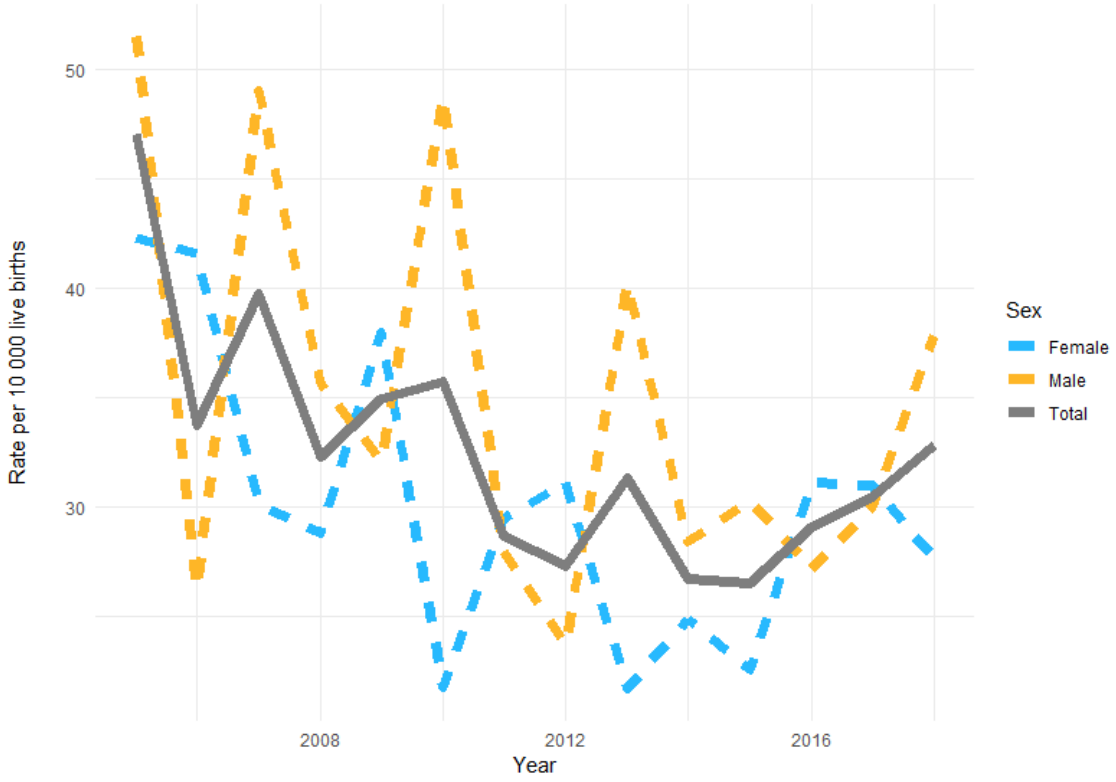

Figure 13: Death rate per 10 000 live births by year of death and sex, for children aged less than 12 months, South Australia 2005-2018

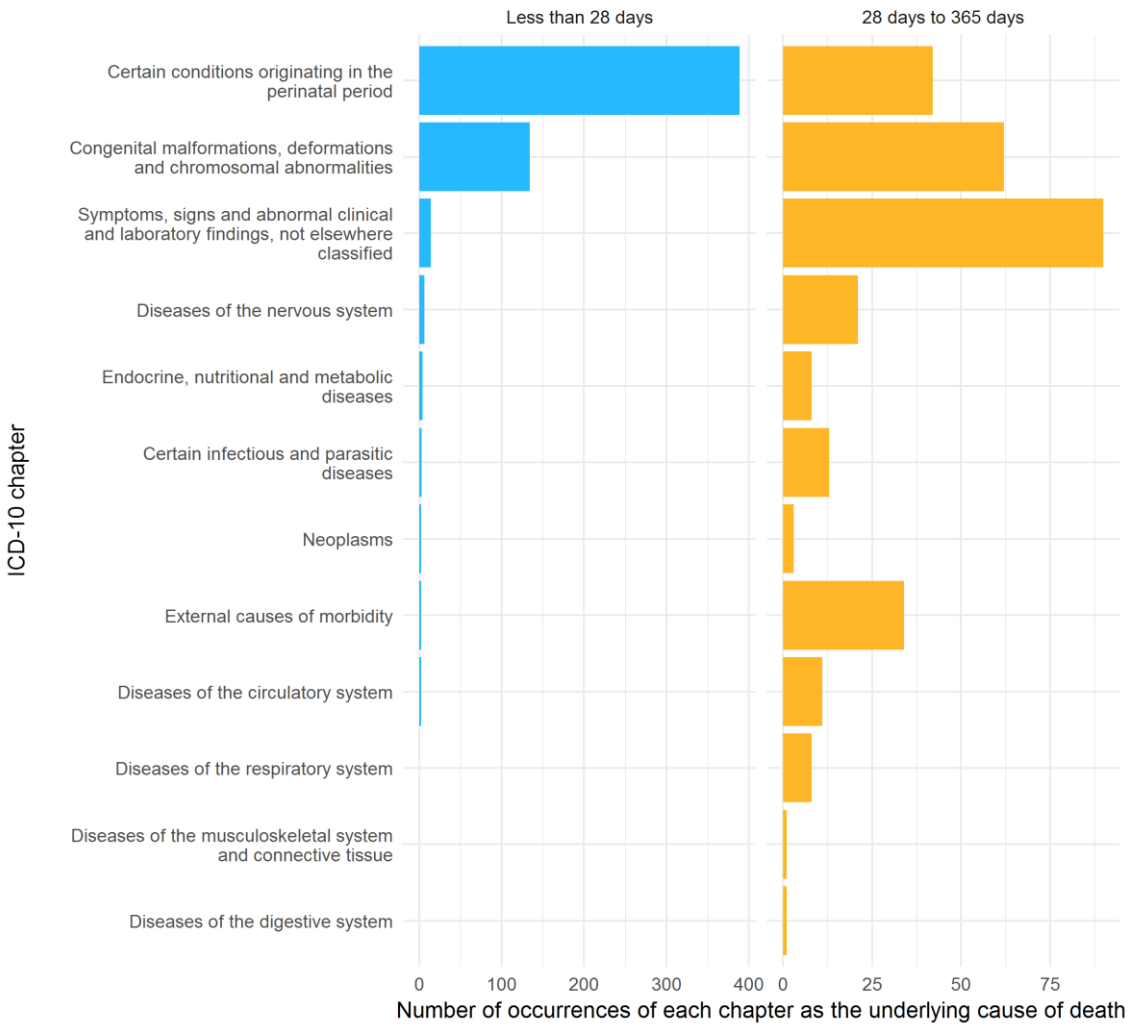

Figure 14: Number of occurrences of ICD-10 chapters, by age at death for children aged less than 12 months, South Australia 2005-2018

The conditions most often associated with the deaths of infants in their first 28 days, were problems occurring during pregnancy and birth. For infants over 28 days of age, the causes of death were more varied.

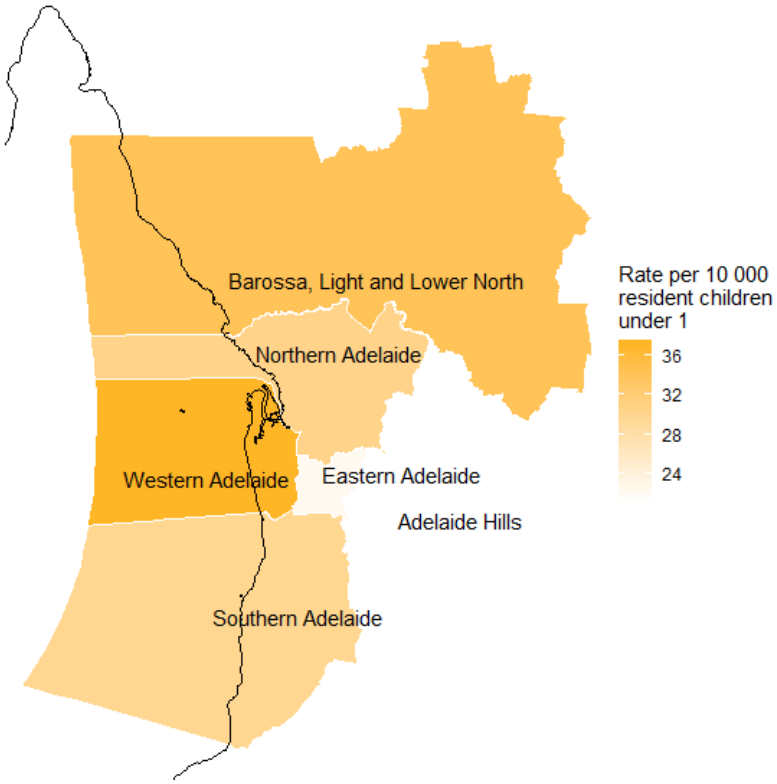

Figure 15: Death rate for children aged less than 12 months by metropolitan and inner rural region, who were usual residents and had a definable geographic region, South Australia 2005-2018

Figure 16 shows that the highest death rate occurred in the Far North region. However, from the perspective of service delivery, it is important to note that the highest number of deaths occurred in the Northern Adelaide region.

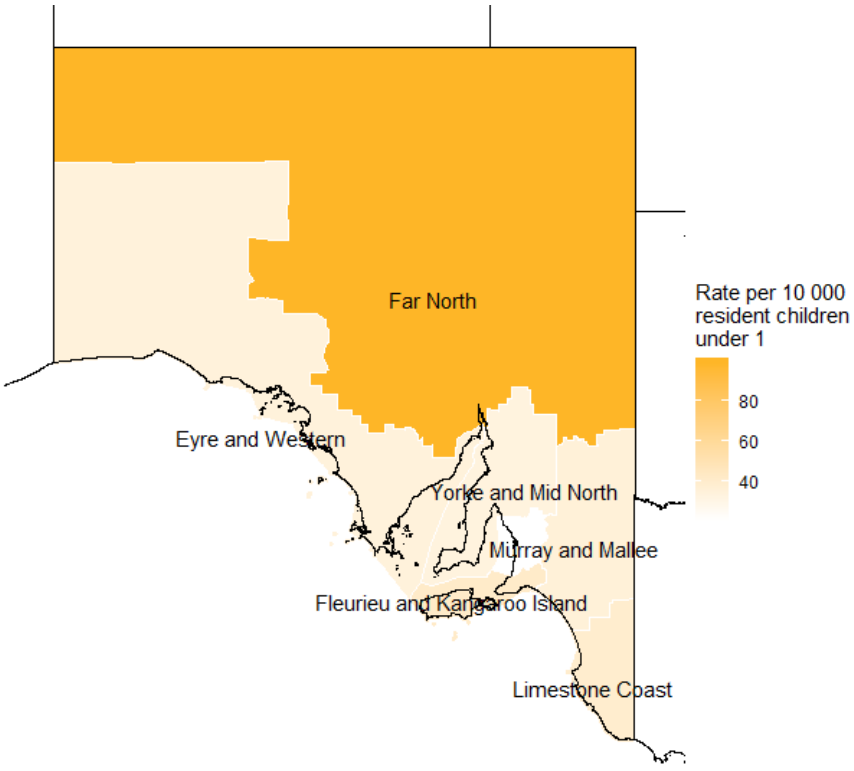

Figure 16: Death rate for children aged less than 12 months by outer rural region, who were usual residents and had a definable geographic region, South Australia 2005-2018

1.6.1. Safe sleeping of infants

The South Australian Safe Infant Sleeping Standards[16] are a comprehensive set of standards for placing infants, less than 12 months of age, to sleep. These standards were developed to help reduce the occurrence of sudden unexpected deaths of infants during sleep. The standards provide a consistent suite of messages that health professionals can use to guide the decisions families make about safe infant sleeping. Several factors occur frequently in the circumstances of these deaths, but are not causes of death in their own right. Rather, they increase the risk of infants dying after being placed to sleep. The factors include:

- the infant not sleeping in an Australian standards-approved cot
- parental smoking
- not breast-feeding

16

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/child+health/safe+infant+sleeping+standards

- bed-sharing
- the infant not being placed on their back to sleep.

Through the careful work of South Australia Police, a great deal of information about the circumstances of sudden unexpected infant deaths is recorded that can help prevent similar deaths from occurring in the future. Between 2005 and 2017, there were 133 cases where an infant died after being placed to sleep. In 123 of these cases, at least one of the identified factors was present.

The Committee has analysed data about the factors that occurred in the circumstances of these deaths. Figure 17 shows these factors and how they co-occur. Some important intersections include:

- in more than three quarters of the cases in which a parent smoked, the infant was not in an approved bed[17] during the fatal sleep episode
- in more than half the cases in which the infant was not breast-fed, a parent also smoked.

[17] *https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/child+health/safe+infant+sleeping+standards*

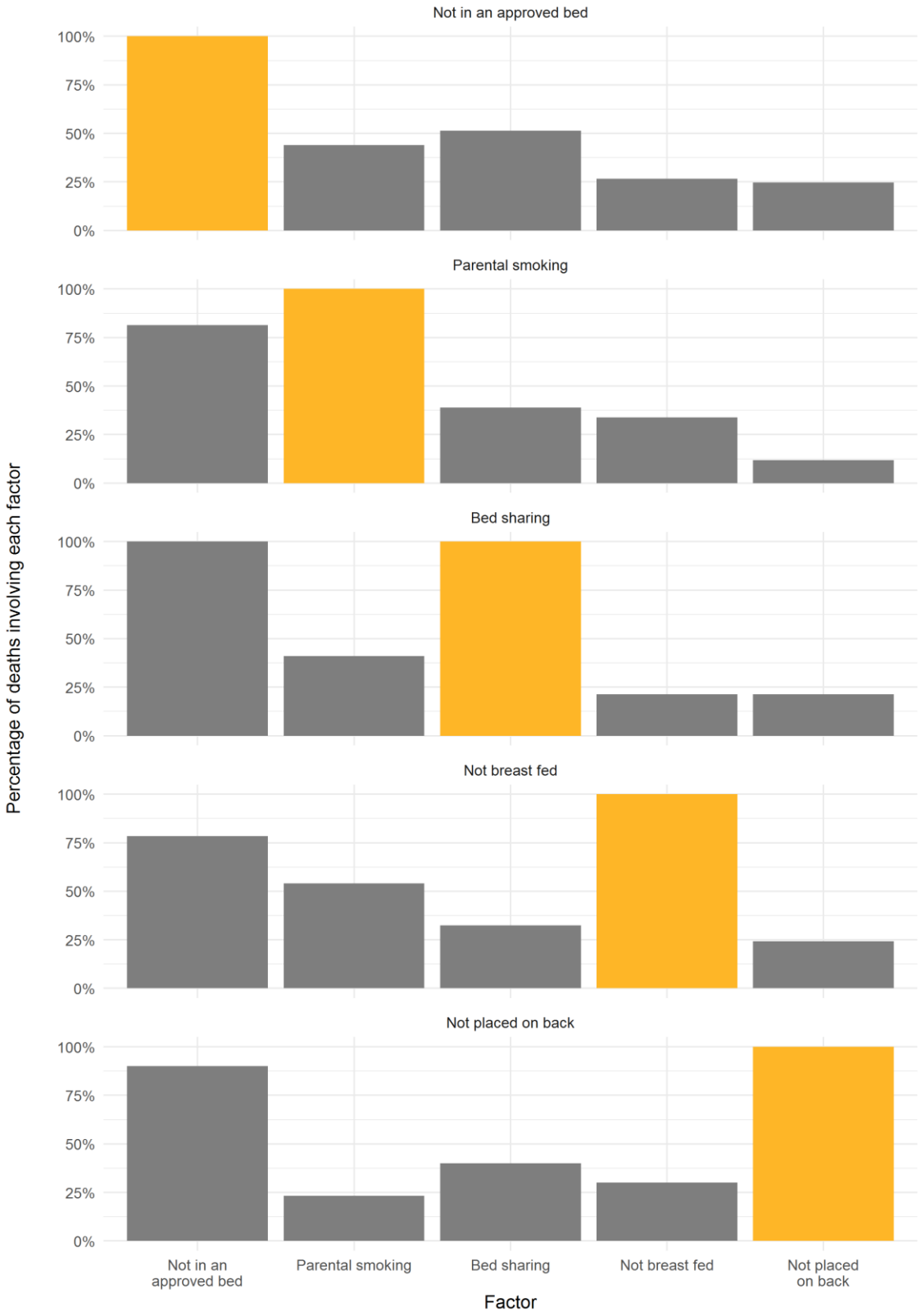

Figure 17: Percentage of deaths involving five unsafe sleeping factors, by each factor, for children aged less than 12 months whose deaths were sudden and unexpected, and occurred after being placed to sleep, South Australia 2005-2017

These data informed recommendations by the Committee in 2006 that all families be provided with an approved bed for their infant to sleep in, along with information about safe infant sleeping[18]. This is particularly true for families living in the most disadvantaged areas of South Australia. As shown in the Committee's April 2018 blog post[19], sudden unexpected infant deaths occur more frequently in the state's most disadvantaged areas.

1.7. Deaths from illness or disease

1.7.1. The number and causes of death from illness or disease

During the period 2005-18, 68% of child deaths in South Australia were attributed to illness or disease. The vast majority of these deaths were of infants under one year of age, and were associated with problems related to labour and delivery, or to chromosomal abnormalities.

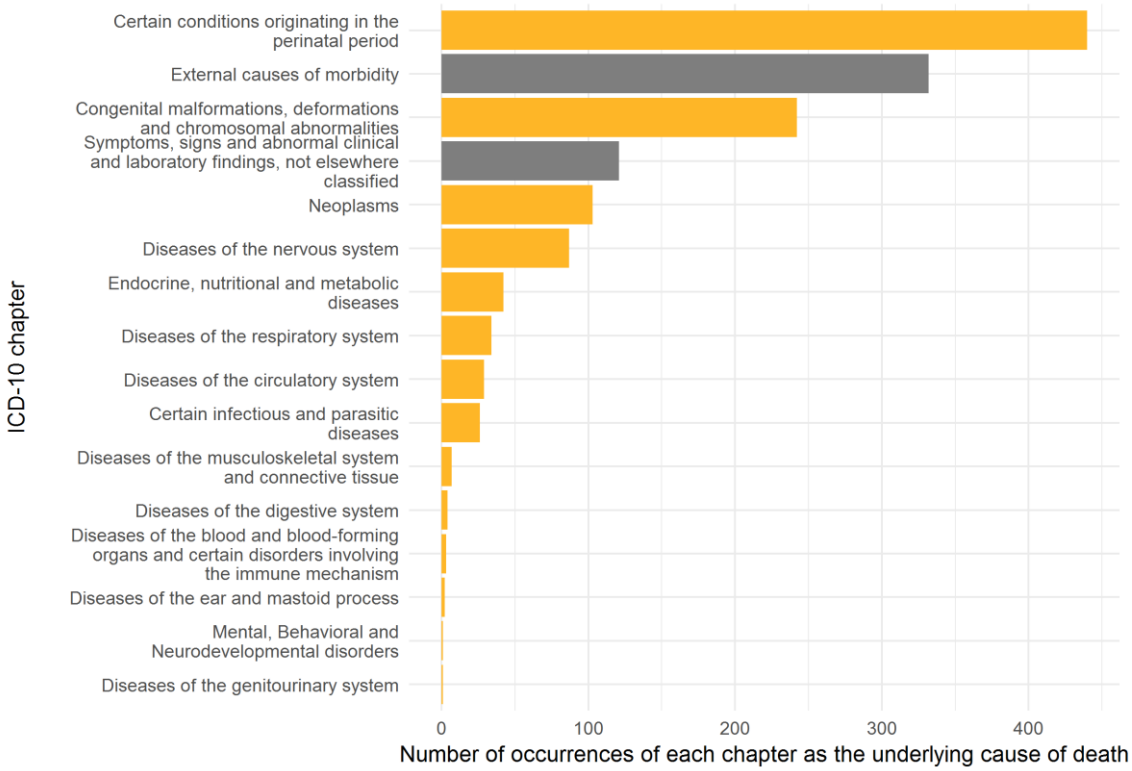

Figure 18: Number of occurrences of ICD-10 chapters, with chapters for illness or disease highlighted, for all children, South Australia 2005-2018

[18] *http://www.cdsirc.sa.gov.au/wp-content/uploads/2017/07/2005-06_cdsirc_annual_report.pdf*
[19] *http://www.cdsirc.sa.gov.au/?p=240*

Figures 19 and 20 show that the highest rate of death occurred in the Far North region. However, from the perspective of service delivery, it is important to note that the highest number of deaths occurred in the Northern Adelaide region.

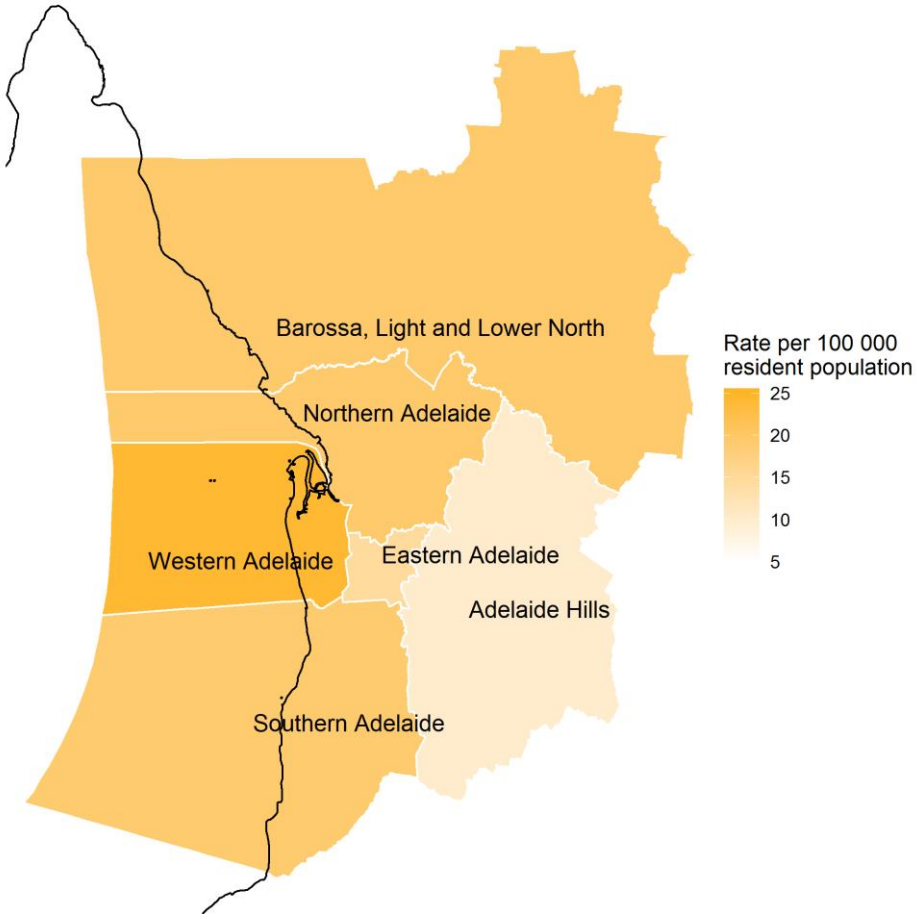

Figure 19: Death rate for illness or disease by metropolitan and inner rural region, for children who were usual residents and had a definable geographic region, South Australia 2005-2018

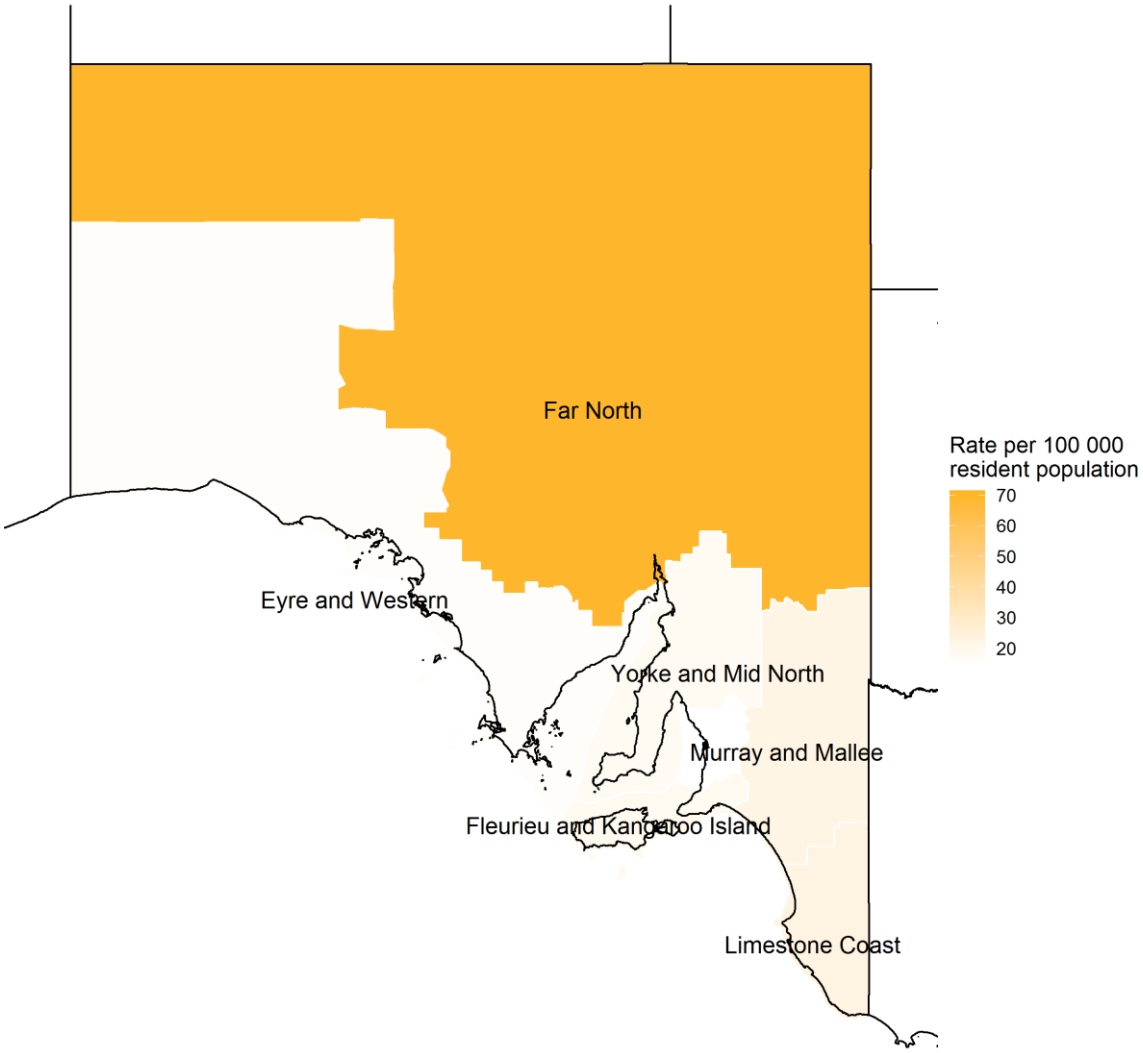

Figure 20: Death rate for illness or disease by outer rural region, for children who were usual residents and had a definable geographic region, South Australia 2005-2018

1.7.2. Monitoring system improvements in the health system

Child deaths attributed to asthma

Between 2005 and 2016, the deaths of 14 children were attributed to asthma. A review of the six deaths that occurred between 2005 and 2010, was submitted to the Minister for Education in 2012. A review of eight subsequent deaths to 2016, was submitted in 2018. The deaths of three more children due to asthma have been recorded since 2016.

Based on the circumstances of death in the 14 cases reviewed to 2016, the Committee recommended an action plan targeting the following issues:

- recognition of poorly controlled asthma
- admission to hospital or presentation to a hospital emergency department, as a trigger for medical review
- specialist care of children with poorly controlled or unstable asthma
- assistance with the cost of ambulance attendance.

In 2017, the Committee communicated the findings of its reviews to the Women's and Children's Health Network's respiratory paediatric services, the Department for Education and Asthma SA. During the period 2018-2019, the Committee presented to:

- Southern Adelaide Local Health Network Paediatric Seminar (April 2018)
- Child and Adolescent Health Community of Practice (CAHCoP) (June 2018)
- Minister for Health (November 2018)
- Department for Child Protection's Senior Practitioners Forum (June 2019).

In 2019, the SA Health Child and Adolescent Health Community of Practice established a state-wide Childhood Asthma Steering Group to review and develop responses to the Committee's recommendations. The Committee will monitor and support the activities of CAHCoP to prevent further deaths of children from asthma.

During 2018-2019, the Department for Education developed an Asthma Care procedure in consultation with Asthma Australia, respiratory medicine, paediatric specialists from South Australian tertiary hospitals, general practitioners, Catholic Education SA and the Association of Independent Schools of South Australia. The procedure describes the requirement for all children and young people diagnosed with asthma, to have a written Asthma Care Plan completed by their treating health professional and parent or guardian. It requires annual review of the Asthma Care Plan, and in line with the Committee's recommendations, a review of the Plan by school and care services when the child has uncontrolled asthma symptoms, or after an asthma attack at school or childcare. The Asthma Care procedure also provides guidelines for asthma first aid.

Where a child has been identified to be at risk of asthma, the department also requires a Health Support Agreement and a Safety and Risk Management Plan. These ensure the identification of risk minimisation strategies specific to the school or care service

the child is attending, and the individualised management and treatment of the child in that environment. The Health Support Agreement must clearly identify where a child's asthma is mild/moderate, severe and/or life threatening.

Social work audit of infant deaths at the Women's and Children's Hospital

The Committee has a long-standing interest in the responses by SA Health to the care of newborns in families experiencing significant disadvantage. Working with families caring for infants in circumstances of vulnerability is recognised by the Committee to be complex, requiring a high level of skill and experience. The added difficulty of the death of an infant provides further challenges to service systems.

The Women's and Children's Hospital (WCH) Social Work Service collaborated with the Committee to conduct an audit into social work responses to the death of an infant. The Committee identified a cohort of 21 infants who had died before one year of age, and had received services from the Women's and Children's Hospital. The WCH Social Work Service audited the available patient records.

The range of circumstances which precipitated families' contact with WCH included:

- birth with expected complications, for example, serious birth defects
- premature birth
- neonatal retrieval after complications of birth
- sudden and unexpected death of an infant who had been born at WCH
- death in the first year of life, due to serious illness which was treated at the WCH.

The following findings of the audit were presented to the Committee in August 2018:

- The WCH Social Work Services had initiated bereavement services for the families experiencing the death of a child in the neonatal period. Services were offered in a timely and contextualised way to families, and included psychosocial support, financial information, assistance with funeral arrangements, grief counselling, travel and accommodation needs, and provision of mementos. A need for funding to support community-based grief and loss services for a longer period was identified.
- A referral to the antenatal program, Strengthening Links, was made for pregnant women experiencing circumstances of higher psychosocial risk. In

some circumstances, an Unborn Child Concern notification was made to the Department for Child Protection.

- The WCH had a consistently seamless referral pathway from the Neonatal Intensive Care Unit to Social Work Services due to the participation of a social worker in clinical care co-ordination meetings, and daily allocation of inpatient referrals.
- An increase in the co-ordination of services and resources for bereavement responses provided by the WCH Social Work Services, could assist in improving the service to families at the time of the death of their infant.
- The opportunity to conduct such an audit provided valuable information about the quality of Social Work Services in response to the death of an infant. If another audit was to be conducted, the assistance of a university specialist centre such as the South Australian International Centre for Allied Health Evidence would be important.

The following actions were taken in the period August 2018 to June 2019:

- In September 2018, the Committee wrote to the Minister for Health and Wellbeing supporting the need for further resources for family bereavement after the death of a neonate. In response, the Minister identified several sources of support for perinatal grief and loss available from services within the Women's and Children's Health Network.
- The WCH regularly reviews the allocation pathways into Strengthening Links to better target assistance for patients with higher psychosocial needs, including those who present to the hospital late in pregnancy.
- The 2019 Closing the Gap funding provided for extra staff within the Aboriginal Family Birthing Program, including social workers and family support workers. This has improved the provision of holistic antenatal care for vulnerable Aboriginal women.

1.8. Deaths from external causes

Deaths from external causes include those deaths that the Committee has classified as being transport-related, by suicide, due to drowning, a deliberate act by another person, fire-related, accidents (falls, suffocation and asphyxiation, poisoning), neglect, and medical misadventure.

1.8.1. The number and causes of death from external causes

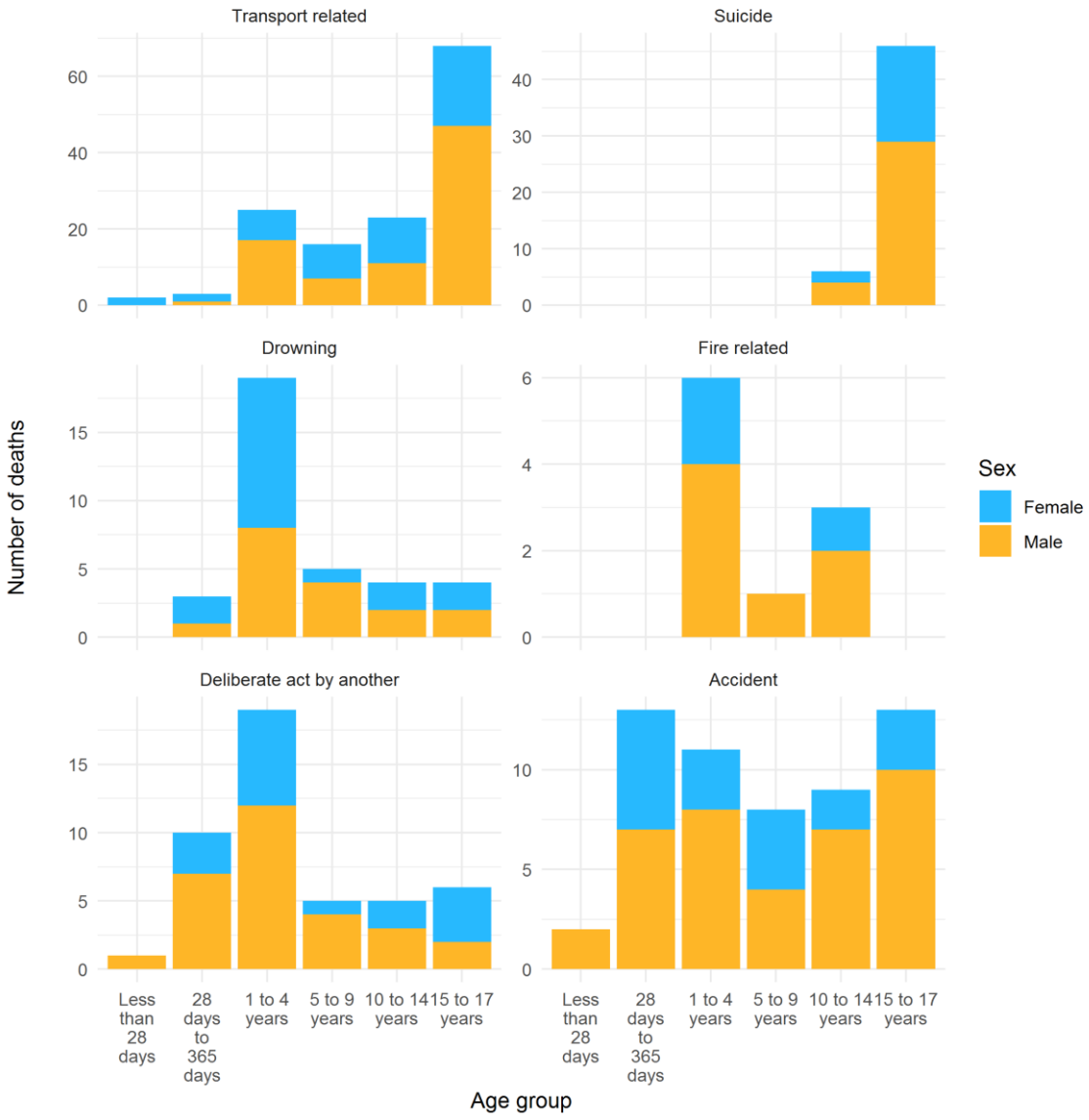

Figure 21: Number of deaths from external causes, by age group and sex, for all children, South Australia 2005-2018

These figures highlight several issues about deaths from external causes:

- with few exceptions, males are more likely to die from external causes, at any age, than females
- the period between one and four years of age is a time of particular vulnerability for children. Deaths due to drowning, a deliberate act by another person, and fire-related deaths, all peak in this age group
- transport-related deaths occur more frequently than any other external cause of death, especially for males in the 15-17 years age group

- in all age groups, with the exception of those children in the 15-17 years age group, a deliberate act by another causes the death of more males than females.

1.8.2. Deaths attributed to drowning[20]

Thirty-five children drowned in South Australia between 2005 and 2018. While these deaths have occurred across the childhood years, 60 percent were of children less than three years of age.

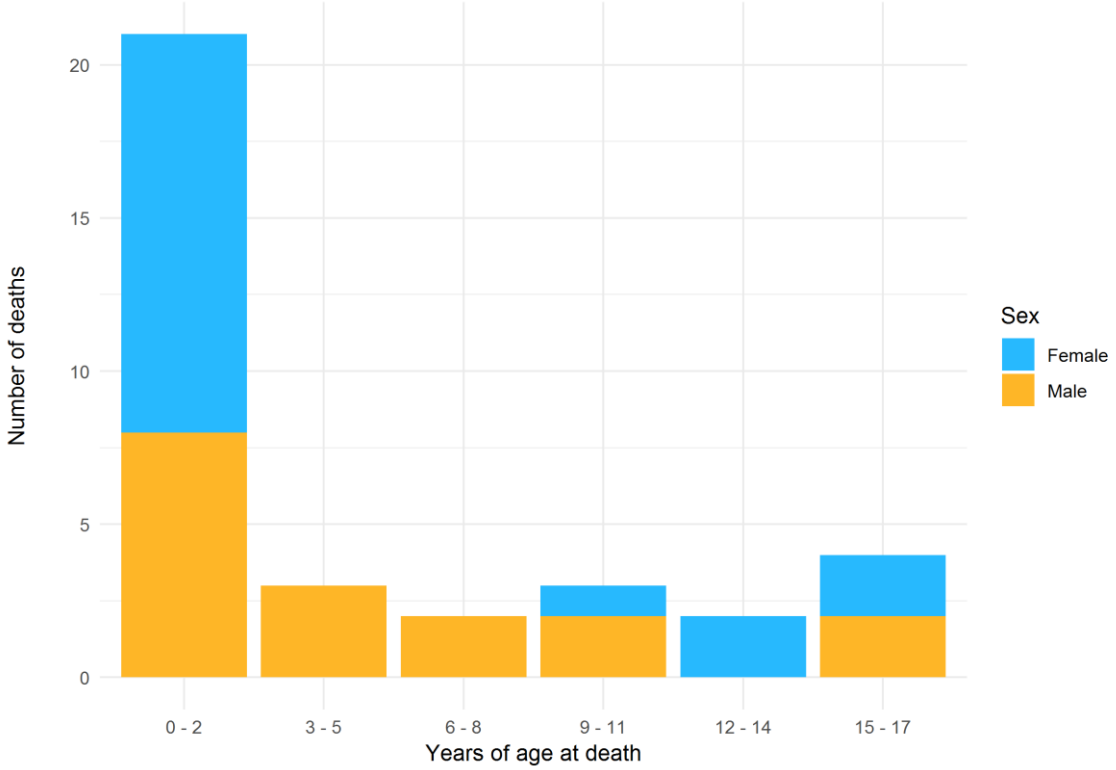

Figure 22: Deaths of children by drowning, by sex and age, South Australia 2005-2018

Any body of water, small or large, can be a risk for childhood drowning. Since 2005, children in South Australia have drowned in a wide range of locations including the sea, pools, ponds, dams, baths and rainwater tanks.

More children died in privately owned locations than in public locations. This difference was particularly pronounced for children under three years of age. This is a highly relevant distinction for the focus of prevention efforts.

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[20] *This information was posted on the Committee's blog, September 2019 http://www.cdsirc.sa.gov.au/?p=605*

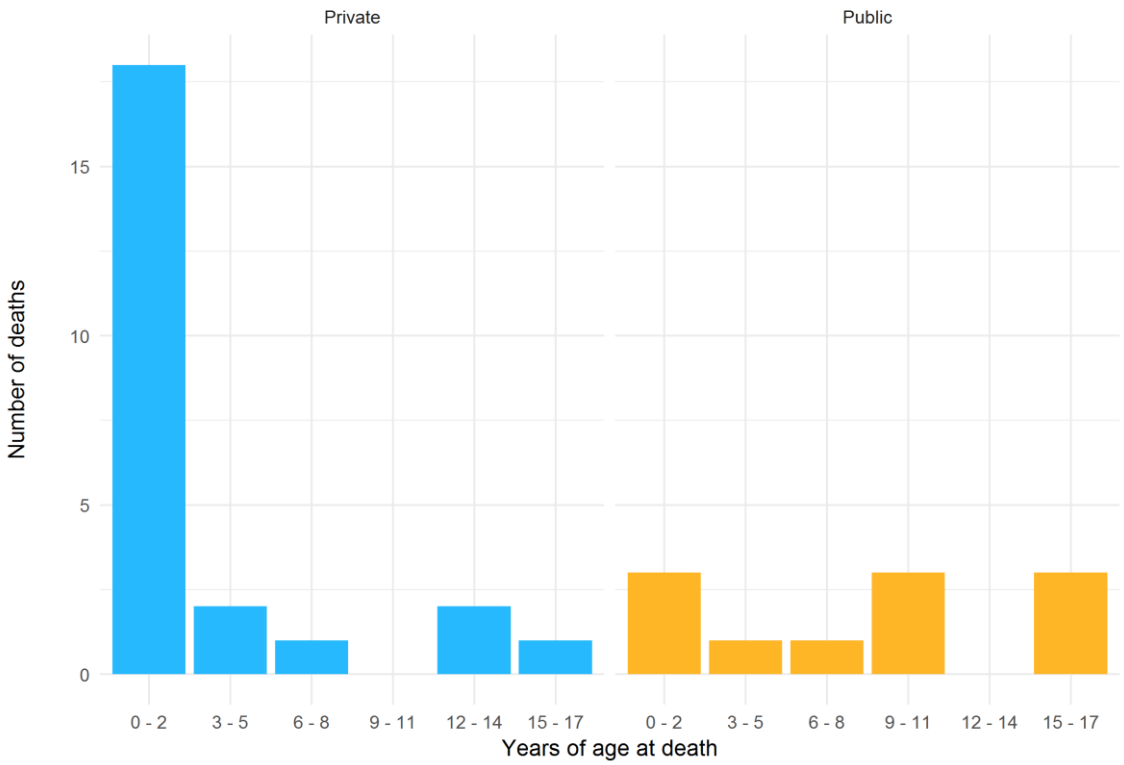

Figure 23: Deaths of children by drowning, by location and age, South Australia 2005-2018

During the summer months, children and adults enjoy spending more time in the water. More deaths of children have occurred in the three summer months than in the rest of the year combined.

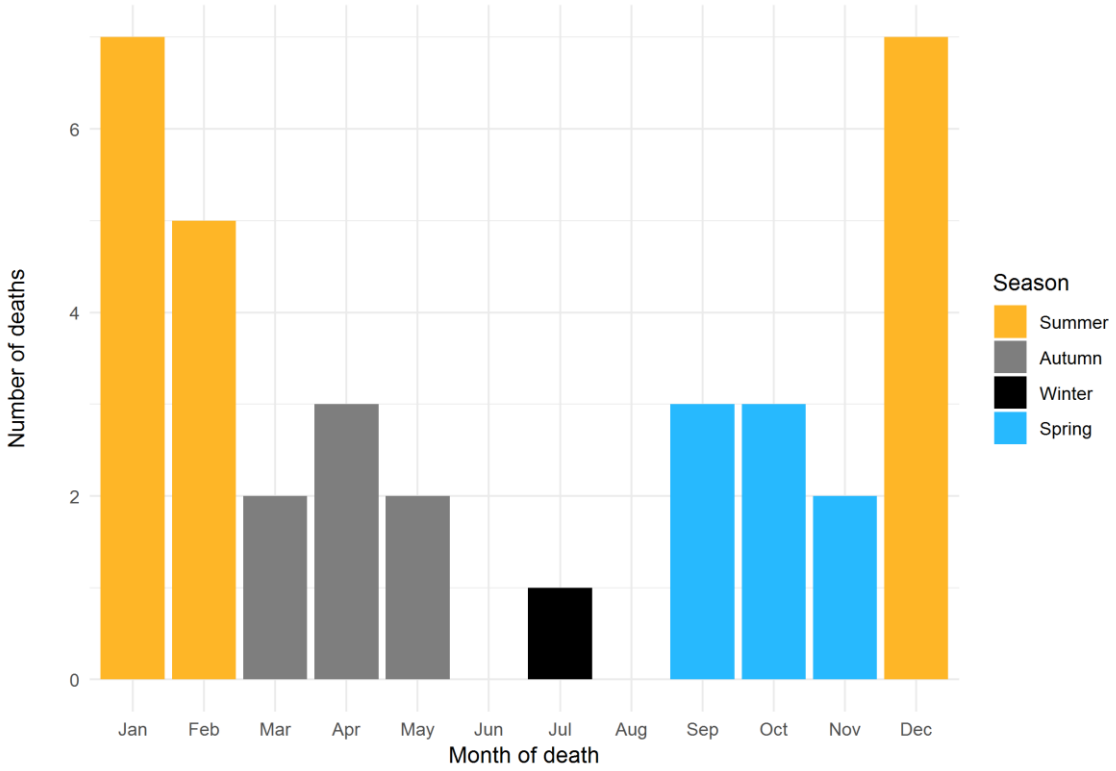

Figure 24: Deaths of children by drowning, by month of death, South Australia 2005-2018

Taking this evidence into consideration, the Committee will continue to support prevention efforts that:

- recognise the importance of legislation and regulations that require maintenance inspections to ensure compliance with pool fencing regulations
- remind parents and caregivers of their role in preventing childhood drowning
- address emerging issues in childhood drowning including the sale of inflatable pools, and the importance of water safety awareness lessons for children and parents, especially those families who have had little or no experience in and around large bodies of water.

1.8.3. Deaths attributed to suicide

Between 2005 and 2018, 52 deaths have been attributed to suicide. Of this number, 33 (63%) were male and ten (19%) were Aboriginal children. These 52 deaths represent 3% of the total number of child deaths between 2005 and 2018. Forty-six of these deaths were of young people aged 15-17 years. Based on the Committee's system for classifying deaths, this makes suicide the third most common cause of death for young people aged 15-17 years.

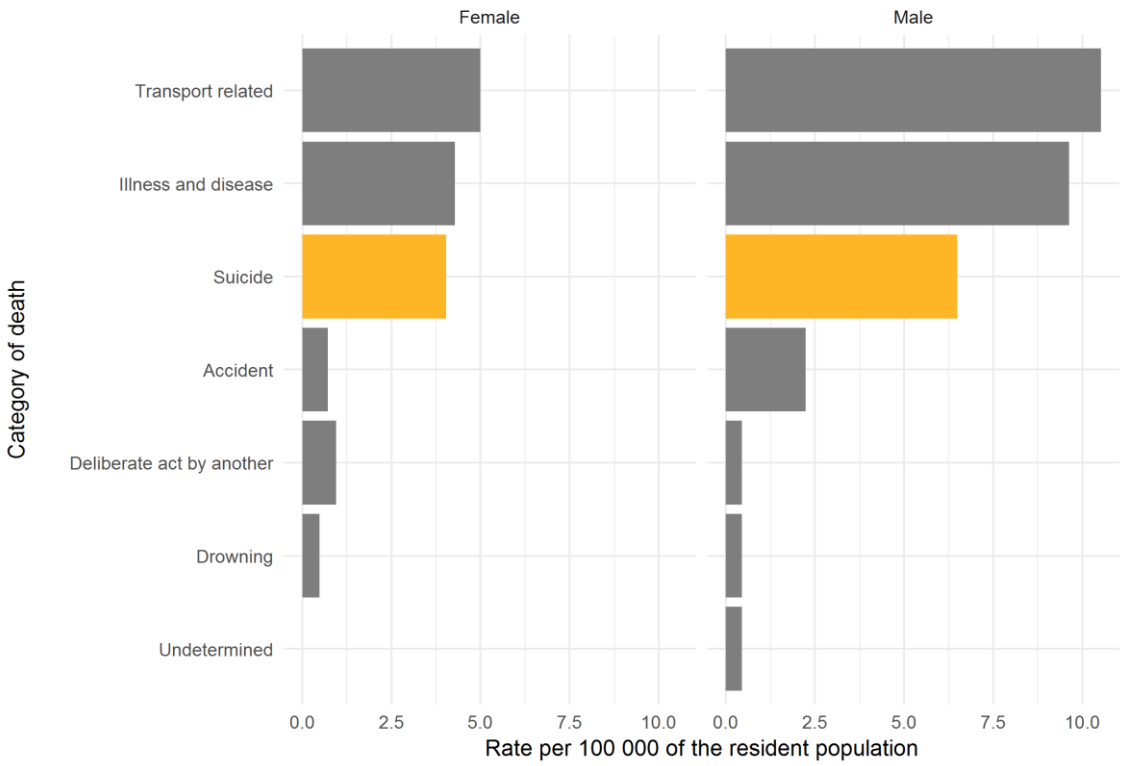

Figure 25: Death rate by category of death, with deaths by suicide highlighted, for young people aged 15-17 years, South Australia 2005-2018

Review of deaths attributed to suicide

The Committee has reviewed 44 suicide deaths using a life chart methodology, which helps to identify common themes in the lives of children and young people who have suicided. Four groups of commonly occurring life chart themes have been identified, as well as recommendations about intervention and prevention strategies to address these themes.

Group 1

The Committee's recommended intervention and prevention strategies for this group are based on the similarities in the life circumstances of 13 children and young people (12 of whom were male). These children and young people faced family, learning and social challenges in their lives from an early age.

Intervention and prevention strategies recommended to address the themes identified in the life charts of these children and young people, should begin early in life, and:

- strengthen parenting capacity within families during the child's very early years

- address learning and behavioural problems as they are identified in early childhood
- ensure that ongoing problems with learning and social skills are addressed, with every effort made to keep the child or young person engaged in education, especially in the transition to secondary school and throughout adolescence
- promote engagement with youth-specific programs in the community, which focus on building resilience and restoring self-esteem
- ensure integrated service delivery including juvenile justice, drug and alcohol services, mental health services and alternative education options.

It is important to note that the intervention and prevention strategies for this group can be overlooked by suicide prevention plans that focus on risk factors, tipping points and imminent harm.

Group 2

The Committee's recommended intervention and prevention strategies for this group are based on similarities in the life circumstances of 23 children and young people (12 of whom were male) who engaged normally with family, school and friends until the emergence of challenges to their mental health, such as depression and/or anxiety.

Intervention and prevention strategies recommended to address the themes identified in the life charts of the children and young people in this group include:

- provision of youth-oriented mental health services with an emphasis on assertive outreach and follow-up, and with the capacity to support the child or young person's family
- co-ordination of mental health services and school support services
- youth-specific services with the capacity to explore issues relating to romantic and sexual relationships.

Group 3

The Committee's recommended intervention and prevention strategies for this group are based on similarities in the life circumstances of five children and young people who had stable home lives, no evidence of mental health challenges, but who had experienced challenges in romantic/sexual or social relationships immediately prior to the event.

Intervention and prevention strategies recommended to address the themes identified in the life charts of the children and young people in this group include:

- readily available and accessible support and information resources – through school, workplace and/or community, as well as 'crisis' support, especially access to help for children and young people during the critical hours when they appear to decide to suicide
- population-based prevention programs that emphasise the role that friends/peers play in helping those who are contemplating suicide.

Group 4

This group comprises three Aboriginal children and young people who lived in rural and remote regions of the state. From an early age, these children and young people were often in the care of extended family. They had frequent absences from school, and faced challenges with learning, communicating and understanding. They were said to be users of marijuana and alcohol.

With very little documentary information available, and the small number of deaths, the Committee is not in a position to comment about prevention strategies tailored to the needs of these children and young people. It is possible that some of the strategies already identified would be relevant to this group.

Monitoring system improvements to prevent suicide

Mental health services

The Committee's 2017-18 Annual Report[21] reported on self-harm hospitalisations for South Australian children and young people. Based on the analysis of this data, and its ongoing review of the suicide deaths of children and young people, the Committee has continued to seek information about the services provided by the Child and Adolescent Mental Health Service (CAMHS). In a meeting with the Acting Clinical Director, CAMHS, two issues regarding service delivery were discussed:

- a differential approach to treatment for children and young people who have had multiple admissions for self-harm within a relatively short period of time

[21] *http://www.cdsirc.sa.gov.au/wp-content/uploads/2018/11/CDSIRC-2017-18-Annual-Report1.pdf*

- the ways in which the transition of young people from CAMHS to adult mental health services is managed, and the suitability of the services available to them in the adult mental health system.

Trialling 'planned admissions' and the establishment of the Borderline Personality Disorder Centre for Excellence[22], were identified as having the potential for service improvements for vulnerable young people.

The Committee has concerns about young people required to transition from CAMHS to adult mental health services. In the Committee's view there are two major issues that increase the vulnerability of these young people:

- the significant differences in the ways in which the youth services model is implemented by local health networks
- the focus on chronicity in adult services is not an appropriate approach to service delivery for young people.

The Committee has written to the Chief Psychiatrist regarding these two issues.

The Committee intends to accept the Acting Clinical Director's invitation to discuss the findings of its work in reviewing suicide deaths in children and young people, with a broader audience of clinicians within CAMHS.

Knowledge about suicide and suicide prevention

The Committee has contributed to the work of the Premier's Council on Suicide Prevention through:

- a presentation at the Youth Suicide Prevention Summit hosted by the Premier's Council and the Office of the Chief Psychiatrist
- membership of the suicide prevention data group which has provided advice about existing data repositories and reports, with a view to assisting the Premier's Council to make decisions about monitoring, evaluation, identification, and profiling of suicide in South Australia.

[22] *https://www.sahealth.sa.gov.au/wps/wcm/connect/33ba8b1b-4b53-42bc-aeb0-446c9ad1ca85/CHSALHN+Borderline+Personality+Disorder+Centre+of+Excellence+Draft+Model+of+Care+v2+080219.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-33ba8b1b-4b53-42bc-aeb0-446c9ad1ca85-mNBPV8d*

Legislation and policies

In July 2019, Parliament passed the Education and Children's Services Bill 2018. The information sharing provisions in this Bill address the issues the Committee raised with the Chief Executive of the Department for Education in March 2019, concerning the importance of a comprehensive handover when a child or young person transfers to another school.

The Minister for Education recently announced an external review which will examine issues about the impact of suspension and exclusion procedures in schools, and schools' responses to issues of truancy and non-attendance. The Committee has raised these issues in previous reviews, and has written to the Minister for Education requesting input into the terms of reference and the scope of this review.

Bullying and the suicide of children and young people

In 2017, a member of the Legislative Council announced his intention to introduce legislation into Parliament that would seek to punish individuals identified as bullies. The Committee wrote to the Honourable Member, setting out its views about the relationship between bullying and suicide. The letter stated that:

> ***In its careful reviews, the Committee has found that the suicide of a young person is never associated with just one issue, such as bullying. There is always a combination of many different factors, some of which may occur very early in a child's life[23].***

Since 2017, the Committee has reviewed several more deaths of children and young people attributed to suicide. Bullying, especially through social media, was said to have played a role in some of these deaths. The Committee acknowledges that bullying can impact the health and wellbeing of a child or young person, but its reviews continue to show that the suicide of a child or young person is always associated with a range of issues.

In her report on bullying in South Australia, the SA Commissioner for Children and Young People acknowledged that effective strategies to address bullying must involve

[23] *Letter from the Committee Chair, 16 October, 2017*

children and young people as perpetrators, victims and bystanders, their parents and families, communities, schools and legislators[24].

This approach to bullying is reflected in the Minister for Education's foreword to the report, released in August 2019, *Connected - a community approach to bullying prevention within the school gates and beyond*, where he states that:

'…(the strategy) establishes our shared understanding of bullying as a complex issue that is driven by the quality of social connections in our community'[25].

The Committee shares the views of the Minister and the Commissioner.

[24] https://www.ccyp.com.au/wp-content/uploads/2018/11/Bullying-Project-Printable.pdf
[25] https://www.education.sa.gov.au/sites/default/files/connected-community-approach-bullying-prevention.pdf

Section Two

2. Committee matters

S30 – Continuation of Child Death and Serious Injury Review Committee

(1) The Child Death and Serious Injury Review Committee established under the *Children's Protection Act 1993* continues in existence.

Children and Young People (Oversight and Advocacy Bodies) Act 2016

2.1. Legislation and purpose

The Child Death and Serious Injury Review Committee operates under Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

The role of the Committee is to contribute to the prevention of death or serious injury of children in South Australia.

The Committee reviews the circumstances and causes of death or serious injury to children, and makes recommendations regarding changes to legislation, policies, procedures or practices of government and non-government agencies.

2.2. Committee matters 2018-19

The Committee met eleven times in 2018-19. In addition to attendance at these meetings, each member contributed their knowledge and expertise to regular meetings of one or more Special Interest Groups, including child protection, health, disability, suicide prevention, and Aboriginal children. In-depth reviews were undertaken by teams drawn from the Committee's membership. The members met as required, to plan and complete each review. The average number of out-of-session meetings of Committee members was two per month.

The Committee continued its work in the following areas:

- the timely and accurate collection of information about the circumstances and causes of child deaths and serious injuries
- identifying cases for review, and undertaking reviews of deaths and serious injuries
- making recommendations to the Minister regarding systemic changes that will contribute to the prevention of similar deaths or serious injuries
- monitoring the progress of the implementation of recommendations
- contributing to government and community knowledge and understanding of the causes of child deaths and serious injuries, and how to prevent them
- maintaining links with interstate and national bodies undertaking similar work.

2.3. Governance and support

From 17 May 2018, the administration of the provisions governing the Committee, were given to the Minister for Education, under *the Administrative Arrangements Act 1994*.

In this reporting period, the Chair met with the Minister for Education on two occasions.

The Committee was supported, in this reporting period, by:

Dr Sharyn Watts	Executive Officer (1.0FTE)
Ms Rosemary Byron-Scott	Senior Project Officer (0.4FTE, January – June 2019)
Dr Owen Churches	Senior Statistician (1.0FTE)
Ms Una Sibly	Senior Project Officer (0.4FTE)
Ms Nikki Kearney	Administration and Information Officer (1.0FTE)

Financial and human resource management support is provided by the Department for Education.

Review of the Act

In April 2019 the Committee, along with the three other bodies established under the Act, contributed to the terms of reference for a review of the Act. In August 2019, the Committee provided its submission to the reviewer who will report to the Minister for Education in November 2019.

Across-government savings

In February 2019, the Committee's Chair wrote to the Minister, confirming the Committee's understanding of the need to consider the ways in which it could contribute to whole-of-government savings targets. In this letter, the Chair emphasised the importance of maintaining the independence of the Committee, the security and confidentiality of its records, and the working conditions required to undertake the work of death review and enable the Committee to fulfil its statutory obligations. The Committee will continue to work with the Minister's nominees with regard to this issue.

2.4. The ANZCDR & PG

In June 2018, following its successful three-year period of chairing the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR & PG), the

Committee passed this responsibility on to the NSW Child Death Review team, which operates under the auspices of the NSW Ombudsman.

The Committee continues to support the work of the ANZCDR & PG. Dr David Everett (Committee member) and Ms Una Sibly (Senior Project Officer) attended the annual two day meeting held in Sydney in April 2019.

Follow-up from that meeting has included teleconference meetings to assist with progressing the group's intention to pursue the development of a national child death database.

2.5. Future directions

In 2019-20, the Committee's work will focus on:

- Timely and accurate collection and analysis of information about child deaths and serious injuries, and especially:
    - improvements to the storage of information about child deaths through enhancements to the database
    - linkage of child death data to other large administrative data sets.
- Review of child deaths and serious injuries, with special regard to:
    - children who had contact with the child protection system after the implementation of reforms resulting from the Royal Commission into Child Protection Systems
    - children and young people whose deaths are attributed to suicide, using the life chart methodology
    - children with disability
    - Aboriginal children, and children from culturally and linguistically diverse backgrounds.
- Monitoring the implementation of recommendations arising from previous reviews, especially with regard to:
    - children in State care, and children with disability
    - evidence of response to issues of neglect and cumulative harm
    - the safe sleeping of infants

- legislation, policies, procedures and models of care that impact the safety and wellbeing of children
- product safety issues, including water heater regulations, swimming pool safety, and legislation relating to quad bikes.

- Participation in work to advance national-level monitoring of child deaths, and through contribution to the national meetings of the ANZCDR & PG.
- Promoting the value of the analysis and outcomes of child death review to key stakeholders through:
  - the quarterly release of topic-specific analyses on the Committee's website
  - the annual report
  - presentations targeted to the interests of legislators, policy-makers and practitioners engaged in the provision of services to children and their families.

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Section Three

3. Methodology

3.1. Sources of information

3.1.1. Sources of information regarding a death

The *Children and Young People (Oversight and Advocacy Bodies) Act 2016* that articulates the role and functions of the Committee, empowers it to request information about a case of child death or serious injury from any person (whether or not the person is a state authority, or an officer or employee of a state authority). Using this power, the Committee receives information regarding the death of a child from a range of sources, and uses this information in its determinations. Importantly, spatial analyses in this report, which include analyses of deaths across the regions of South Australia and across the levels of Socio-Economic Indexes for Areas (SEIFA), uses the postcode of the usual residence of the child who has died. However, the Committee has not been able to determine a South Australian postcode for eleven children who were thought to be South Australian residents. Without this information, these deaths are not included in spatial analyses, but are included in all other analyses.

3.1.2. Sources of information regarding births

The Committee receives the number of live births for each year from the Department for Health and Wellbeing's Pregnancy Outcome Unit.

3.1.3. Sources of information regarding populations across calendar year, single year of age, sex and cultural background

The Committee acquires the publicly available number of children resident across the dimensions of calendar year, single year of age, sex, cultural background and postcode from the Australian Bureau of Statistics (ABS). The ABS's five yearly census provides a count of the number of children resident in South Australia within the year of the census by single year of age, sex, cultural background and postcode. The ABS also provides an estimate of the number of children resident in South Australia for each single calendar year.

For the purpose of this report, the population of children resident in South Australia by calendar year, single year of age, sex, cultural background and postcode is interpolated as follows: the counts across single year of age, sex, cultural background and postcode are taken from the census, and assigned to the calendar years as three

years before each census to two years after the census. The multiplier needed to get from the census to the estimate for each year is found, and is then applied to each of the 344736 cells in the matrix calendar year (14 levels), age (18 levels), sex (2 levels), cultural background (2 levels), and postcode (342 levels). Note that when re-aggregated, the adjusted count is the same as the estimate.

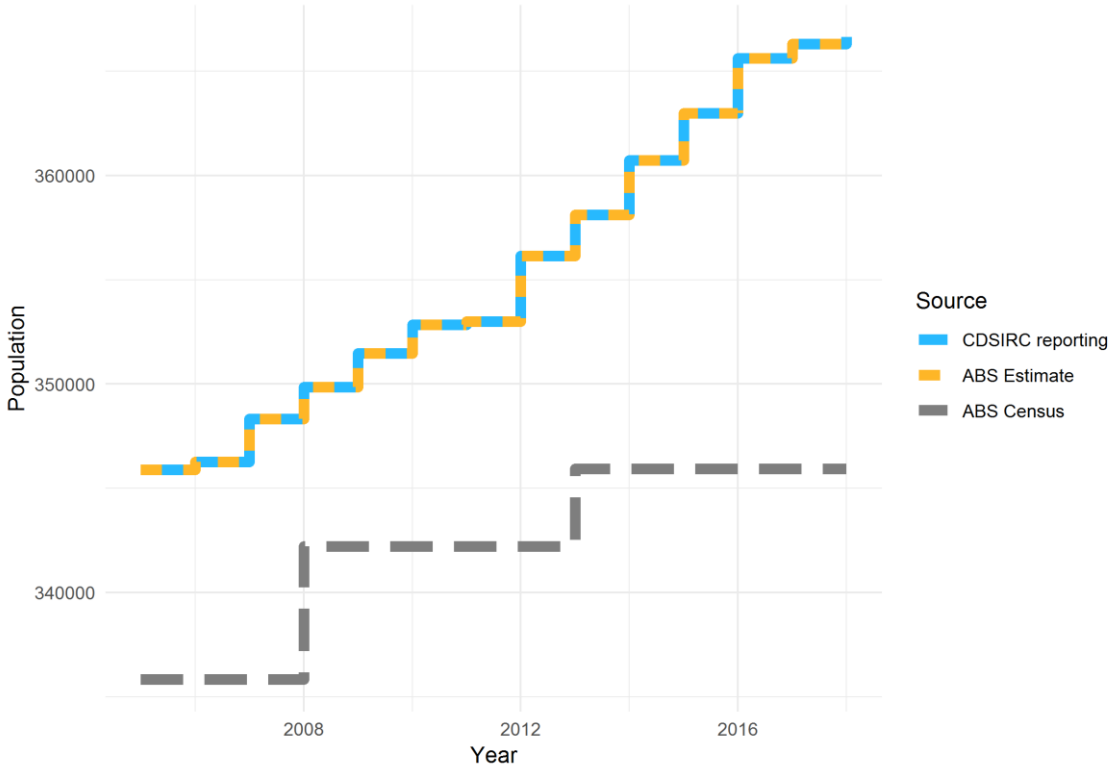

Figure 26: Populations of South Australian children aged 0 to 17 years, from the original sources, and the population 2005-2018 used in this annual report

3.1.4. Sources of information regarding SEIFA

For the purpose of this report, the Committee used the measure of relative disadvantage Socio-Economic Indexes for Areas (SEIFA) decile within South Australia, for each South Australian postcode acquired from the ABS census publications from 2016, and collapsed the deciles into quintiles. The postcode of the usual residence of each child who died, and who was a usual resident of South Australia, was matched to the appropriate SEIFA level. On this scale, quintile 1 includes areas with the greatest relative socio-economic disadvantage and quintile 5 includes areas with the least relative socio-economic disadvantage.

3.2. Operational definition of death used in the report

The Committee receives information regarding the death of a child in South Australia from three government sources: Births, Deaths and Marriages, the State Coroner's Court and the Pregnancy Outcome Unit. The count of deaths in this annual report includes all cases received from these sources with the following exceptions:

- if the Committee understands from the information gathered that the case was a termination of pregnancy
- if the Committee understands that the death occurred after the birth of an infant, prior to 20 weeks gestation.

Where there is disagreement between the sources, the Committee reviews all of the available evidence to arrive at a conclusion.

3.3. Cultural background

To differentiate grouping, the ABS uses the categories of 'Aboriginal', 'Torres Strait Islander', 'Both Aboriginal and Torres Strait Islander', 'Not stated' and 'Non-Indigenous'. For the purpose of this report, the Committee collapses these categories into two groups: 'ATSI' = 'Aboriginal', 'Torres Strait Islander', 'Both Aboriginal and Torres Strait Islander'; and 'Other' = 'Not stated' and 'Non-Indigenous'.

It is important to note the Committee's determination of the cultural background of a deceased child uses multiple administrative sources and is a different methodology than that used by the ABS which is based on the self-report of the person completing the census form. There are good reasons to think that these are different[26].

3.4. Sudden Unexpected Deaths in Infancy

Sudden Infant Death Syndrome (SIDS) is a term used to describe the sudden and unexpected death of an infant who is less than one year of age, when the death occurs during sleep, and when the cause of death remains unexplained after a complete autopsy, review of the circumstances of death, and of the child's clinical history[27].

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[26] *Gialamas A, Pilkington R, Berry J, Scalzi D, Gibson O, Brown A, Lynch J. Identification of Aboriginal children using linked administrative data: Consequences for measuring inequalities* Journal of Paediatrics and Child Health 52 (5), *534- 540.*

[27] *Krous H, Beckwith J, Byard R, Rognum T, Bajanowsky T, Corey T, Gutz E, Hanzlik R, Keens T, and Mitchell E. (2004) Sudden infant death syndrome and Unclassified infant deaths: A definitional and diagnostic approach.* Paediatrics, 114*, 234 – 238.*

A recent development in the classification of sudden infant deaths, is the use of the term Sudden Unexpected Death in Infancy (SUDI). This is an umbrella term used not only to describe cases of SIDS, but all deaths of infants aged less than 12 months that are sudden and unexpected[28].

3.5. The Committee's classification of cause of death

In many cases, the Committee has multiple sources of information available about children, and is not limited to the causes of death recorded in post-mortem reports or death certificates. At the time of classifying a death, the Committee will consider all available information.

Table 3: Committee's cause of death classification

Cause	Committee classification
Transport–related	Transport-related deaths include deaths resulting from incidents involving a device used for, or designed to be used for, moving people or goods from one place to another. These incidents may involve pedestrians and include railway or water transport.
Accidents	Accidents exclude deaths attributed to transport incidents, fires or drowning. Also referred to as deaths from unintentional injuries, these deaths most commonly include accidental: suffocation, strangulation and choking, falls and poisoning.
Suicide	The Committee's definition of suicide is: *Taking one's own life, intending to do so.* The Committee defines a death as suicide if, after a thorough review of all available evidence, it is satisfied that the young person killed him or herself intending to take their own life. Since adopting this definition, three cases previously attributed to suicide have been reclassified as accidental deaths, resulting from misadventure.
A deliberate act by another causing death	Describes a range of deaths, including deaths from acts of violence, where a person, by whatever means, causes a child's death by a deliberate act. While a person's intent is obviously relevant to issues of criminal liability, for the Committee's categorisation of deaths this does not need to be considered. Similarly, there may be cases where the person who causes a child's death does so as a result of mental illness, leading to a Court finding of mental incompetence. Such cases are also included in this category. It will not always be possible, on the basis of the available evidence, to be certain that a child's death resulted from a deliberate act by another person. For instance a child may have serious head injuries causing death, where it is not possible to say that the injuries were deliberately inflicted, as opposed to being caused by an accidental fall. In such cases, upon consideration of all the available evidence, the Committee will decide which is the most likely cause of death.
Neglect	The Committee defines neglect as 'a death resulting from an act of omission by the child's carer(s)' including: • failure to provide for the child's basic needs

[28] *Byard R, and Krous H. (2001)* Sudden Infant Death Syndrome: Problems, Progress and Possibilities. *Taylor & Francis.*

	• abandonment • inadequate supervision, and • refusal or delay in provision of medical care. This definition can account for both chronic neglect and single incidents of neglect, or a combination of both[29].
Health-system related	These deaths have been classified as such by the Committee based on written records which may not necessarily be complete. The Committee places a death in this category based on consideration of preventable aspects in the circumstances of the death, and a focus on future prevention strategies rather than an investigation of the cause of death.
Sudden unexpected infant death	Sudden Unexpected Death in Infancy (SUDI) has been described as an 'umbrella' term that is used for all sudden unexpected deaths of infants younger than one year of age. The definition of SUDI is based on the definition, proposed by Fleming et al. (2000)[30], and includes infants from birth to 365 completed days of life whose deaths: Criterion 1: Were unexpected and unexplained at autopsy; Criterion 2: Occurred in the course of an acute illness that was not recognised by carers and/or by health professionals as potentially life-threatening; Criterion 3: Arose from a pre-existing condition that had not been previously recognised by health professionals; or Criterion 4: Resulted from any form of accident, trauma or poisoning.
Sudden infant death syndrome	The criteria used to determine a death attributed to SIDS continues to be the San Diego definition proposed by Krous et al. (2004, see Table 21). Death rates for SIDS are reported per 100 000 livebirths.

3.6. Disability

The definition used to determine inclusion as the death of a child with disability for children 1-17 years old is:

- the child was over one year of age at the time of death
- the child's daily activities were limited due to their disability, illness, disease or health problem; and
- the child's daily activities were adversely affected for a period of six months or more.

Where the length of time during which the child's daily activities were adversely affected was unknown, the case was not included on the register. Cases where the child had a chronic health condition (eg, asthma, epilepsy, diabetes), were only included on the register if other disabilities were present. Some children have multiple types of disability, for example cerebral palsy and epilepsy. Multiple disabilities are recorded for each child where they have been identified.

[29] *Lawrence R, & Irvine P.* Redefining fatal child neglect. Child Abuse and Prevention, 21, *1-22.*
[30] *Fleming P, Bacon C, Blair B, and Berry PJ. (2000)* Sudden unexpected deaths in infancy, the CESDI studies 1993-1996. *London: The Stationery Office.*

Table 4: Committee's definition of disabilities

Disability	Committee definition
Neurodegenerative diseases, genetic disorders and birth defects	This category included all instances of neurodegenerative diseases, genetic disorders and birth defects, including in-born errors of metabolism where the child's health deteriorates over time. Children with many of these conditions are likely to die as a result of their disease, and they require significant care as their condition progresses.
Cerebral palsy	This category included all cases of cerebral palsy, which is a term used to describe a group of non-progressive motor function disorders that arise because of damage to, or dysfunction of, the developing brain. This permanent condition can affect body movement, muscle control, muscle coordination, muscle tone, reflex, posture and balance. It may also cause visual, learning, hearing, speech and intellectual impairments, as well as epilepsy.
Epilepsy	Using the guidelines developed to identify disability, this category only included cases where the frequency and severity of the child's epilepsy adversely affected their daily activities for a period of six months or more, or the child with epilepsy had associated disability. Epilepsy is a common disorder that is characterised by recurring seizures or sudden, uncontrolled surges in the normal electrical activity in all, or part of, the brain. While the Epilepsy Centre notes that epilepsy can mostly be controlled by taking medication and restricting daily living activities, epilepsy can be associated with sudden unexpected death.
Heart and circulatory problems	This category included all cases where a condition involving the heart or blood vessels was able to be identified, regardless of whether the condition resulted from an infection or from a birth defect. Children with conditions such as complex congenital heart defects or myocardiopathy are, without life-saving surgery such as a heart transplant, at higher risk of dying as a result of their heart or circulatory problems.
Intellectual disability	This category included all cases where the available information suggested that the child had some form of intellectual disability. It was identified as a specific category because it is a developmental disorder, and people living with such disorders have significantly more difficulty than others in integrating new learning, understanding concepts and solving problems.
Autism spectrum disorder	Autism Spectrum Disorder is a lifelong developmental disability that affects, among other things, the way a child relates to his or her environment, and their interactions with other people. Where information was available indicating a diagnosis of ASD had been made, the child was placed in this category.
Other types of disability	This category accommodated all of the remaining disability types in children on the Disability Register. It incorporated cases where a child had conditions such as Epstein-Barr virus, systemic lupus, and community acquired pneumonia. It also included cases where the available information was too limited to confidently assign the case to a specified category.
Cancer and 'disabling medical conditions'	The Disability team considered that the issues arising from these deaths were primarily about the medical management of these conditions rather than about issues arising from the disability caused by their impact on the child. These deaths will be reported as deaths from illness or disease.

3.6.1. Infants with disability

There is a unique set of challenges associated with identifying disability in infants. A set of criteria has been developed by the Committee to identify the deaths of infants with a disability. Deaths are excluded from consideration if the underlying cause is: prematurity alone; prematurity and maternal factors; infection; haemorrhage; digestive or respiratory problems; cancer; heart disease, including myocarditis and

cardiomyopathy; or, congenital malformations of major organs such as heart, kidney and liver.

Once these cases are excluded, the remaining deaths are then reviewed by the Disability team, and a decision made about inclusion in the Disability Register based on the available information. Multiple types of disability are not recorded for infants under one year of age.

3.7. Deaths of children in contact with the child protection system

To be included in this section of the report, the child or a member of their family must have had some form of contact with DCP or its predecessors, within three years of the incident resulting in their death. The guardianship status of a child or their parent(s) is determined during this process, whether in South Australia or in another Australian state or territory.

3.8. Coding death using ICD-10

All deaths registered by the Committee are coded according to the International Classification of Diseases, Version 10 (2016) developed by the World Health Organization. This system is accepted as the world standard diagnostic classification system for all general mortality and morbidity classifications[31].

3.9. In-depth review process

Deaths screened by the Committee are assigned one of the following criteria:

- Eligible for review - a case will only be considered eligible for review under Section 37(2) of the Act, if the incident resulting in the death or serious injury occurred in the state; or the child was, at the time of their death or serious injury, ordinarily resident in the state.
- Not for review - a case may not require in-depth review if the screening of information available at the time, indicated that there are no systemic issues arising from the death. These cases are assigned a category of death, eg,

[31] *https://www.who.int/classifications/icd/icdonlineversions/en/*

illness or disease, SUDI, transport, deliberate acts etc, and the details are kept on the Committee's database. They are included in the relevant annual report. They may be included in reviews in later years, where features from cases aggregated over a number of years, suggest that there may be systemic issues that can be addressed.

- Pending further information - in some cases the Committee requests further information before making a decision regarding in-depth review.
- Pending completion of investigations - in accordance with Section 37(4) of the Act, the Committee must not undertake a review if there is a risk that the review would compromise an ongoing criminal investigation, and must wait until coronial investigations are complete.
- Awaiting assignment - in any reporting year, there are also cases ready for review but awaiting assignment to a 'review team'. The number of cases pending investigation or review gradually decreases during any year as information is obtained, cases are finalised in the criminal and coronial systems, and the Committee makes a determination about further review.

3.10. Reporting requirements

Section 39 of the Act outlines the reporting responsibilities of the Committee. It requires the Committee to report periodically to the Minister for Education, and also to provide an annual report on the performance of its statutory functions for the preceding financial year. The Committee submits a report to the Minister for Education at the conclusion of each in-depth review. The report contains the Committee's recommendations about systemic or legislative issues that may contribute to the prevention of similar deaths or serious injuries.

Section Four

4. Data tables

Data table 1: Death rate by year of death and sex for all children, South Australia 2005-2018

Year	Sex	Number of deaths	Death rate per 100 000 resident population
2005	Female	58	34.45943
2005	Male	78	43.92655
2005	Total	136	39.31965
2006	Female	70	41.54405
2006	Male	49	27.56508
2006	Total	119	34.36754
2007	Female	42	24.7788
2007	Male	80	44.73767
2007	Total	122	35.02526
2008	Female	44	25.83681
2008	Male	70	38.98324
2008	Total	114	32.58409
2009	Female	57	33.317
2009	Male	70	38.80456
2009	Total	127	36.13344
2010	Female	40	23.28937
2010	Male	77	42.51892
2010	Total	117	33.15875
2011	Female	49	28.51712
2011	Male	57	31.4614
2011	Total	106	30.02824
2012	Female	48	27.68791
2012	Male	51	27.90055
2012	Total	99	27.79704
2013	Female	44	25.27126
2013	Male	64	34.78276
2013	Total	108	30.15833
2014	Female	41	23.37784
2014	Male	55	29.67516
2014	Total	96	26.61344
2015	Female	38	21.53165
2015	Male	54	28.95325
2015	Total	92	25.34491
2016	Female	45	25.31459
2016	Male	57	30.34192
2016	Total	102	27.89766
2017	Female	56	31.44369
2017	Male	54	28.69122
2017	Total	110	30.02946
2018	Female	45	25.24458
2018	Male	59	31.31969
2018	Total	104	28.36601

Data table 2: Death rate by year of death and sex for children who were usual residents, South Australia 2005-2018

Year	Sex	Number of deaths	Death rate per 100 000 resident population
2005	Female	52	30.89466
2005	Male	71	39.98443
2005	Total	123	35.56116
2006	Female	62	36.79616
2006	Male	47	26.43997
2006	Total	109	31.47951
2007	Female	42	24.7788
2007	Male	74	41.38234
2007	Total	116	33.30271
2008	Female	39	22.90081
2008	Male	65	36.19872
2008	Total	104	29.72584
2009	Female	53	30.97897
2009	Male	68	37.69586
2009	Total	121	34.42635
2010	Female	38	22.12491
2010	Male	77	42.51892
2010	Total	115	32.59194
2011	Female	47	27.35315
2011	Male	54	29.80554
2011	Total	101	28.61182
2012	Female	45	25.95741
2012	Male	49	26.80641
2012	Total	94	26.39315
2013	Female	40	22.97387
2013	Male	58	31.52188
2013	Total	98	27.36589
2014	Female	38	21.66726
2014	Male	52	28.05651
2014	Total	90	24.9501
2015	Female	37	20.96502
2015	Male	50	26.80856
2015	Total	87	23.96747
2016	Female	44	24.75204
2016	Male	56	29.80961
2016	Total	100	27.35065
2017	Female	53	29.75921
2017	Male	53	28.15991
2017	Total	106	28.93748
2018	Female	40	22.43963
2018	Male	59	31.31969
2018	Total	99	27.00226

Data table 3: Death rate by region of metropolitan and inner rural South Australia for children who were usual residents, 2005-2018

Region	Number of deaths	Death rate per 100 000 resident population
Adelaide Hills	44	19.07871
Barossa, Light and Lower North	65	29.98159
Eastern Adelaide	110	22.07364
Northern Adelaide	375	28.4907
Southern Adelaide	276	26.24982
Western Adelaide	188	31.83109

Data table 4: Death rate by outer rural region of South Australia for children who were usual residents, 2005-2018

Region	Number of deaths	Death rate per 100 000 resident population
Eyre and Western	59	30.72371
Far North	88	104.85242
Fleurieu and Kangaroo Island	44	29.67729
Limestone Coast	71	32.52013
Murray and Mallee	78	34.41924
Yorke and Mid North	78	37.12883

Data table 5: Number of deaths by age group and category of death for all children, South Australia 2005-2018

Age Group	Category of death	Number of deaths
Less than 28 days	External causes	5
Less than 28 days	Illness or disease	559
Less than 28 days	Undetermined including SIDS	14
28 days to 365 days	External causes	29
28 days to 365 days	Illness or disease	171
28 days to 365 days	Undetermined including SIDS	97
1 to 4 years	External causes	80
1 to 4 years	Illness or disease	107
1 to 4 years	Undetermined including SIDS	13
5 to 9 years	External causes	35
5 to 9 years	Illness or disease	74
5 to 9 years	Undetermined including SIDS	2
10 to 14 years	External causes	50
10 to 14 years	Illness or disease	77
10 to 14 years	Undetermined including SIDS	1
15 to 17 years	External causes	137
15 to 17 years	Illness or disease	61
15 to 17 years	Undetermined including SIDS	2

Data table 6: Number of deaths by state, territory or country of residence and cultural background, for children not usually resident in South Australia, 2005-2018

Usual residence	Aboriginal	Other
NSW	1	13
NT	28	17
Outside Australia	0	3
QLD	2	3
TAS	0	2
VIC	2	12
WA	2	6

Data table 7: Number of deaths by age group and relative advantage and disadvantage SEIFA quintile, for children who had a definable SEIFA level in South Australia, 2005-2018

Category of death	SEIFA disadvantage	0 to 1	2 to 3	4 to 5	6 to 7	8 to 9	10 to 11	12 to 13	14 to 15	16 to 17
Accident	1	12	2	1	1	1	2	0	4	3
Accident	2	2	0	0	0	1	0	0	1	1
Accident	3	5	0	1	0	0	0	2	0	2
Accident	4	2	0	0	1	1	1	0	1	2
Accident	5	0	2	0	1	0	1	0	1	1
Drowning	1	11	0	0	0	0	2	0	0	0
Drowning	2	1	1	1	1	0	0	0	0	0
Drowning	3	2	0	0	0	1	0	0	1	0
Drowning	4	2	3	1	0	0	0	1	0	1
Drowning	5	1	1	0	0	0	0	0	2	0
Deliberate act by another	1	5	4	0	1	0	0	1	1	1
Deliberate act by another	2	5	2	2	1	0	0	0	0	3
Deliberate act by another	3	4	1	0	0	0	0	0	0	0
Deliberate act by another	4	1	1	2	0	1	1	0	0	0
Deliberate act by another	5	0	1	2	0	0	0	0	2	1
Fire related	1	0	4	0	0	0	0	0	0	0
Fire related	2	0	0	0	0	0	0	0	0	0
Fire related	3	0	0	0	0	0	0	0	0	0
Fire related	4	0	2	1	0	0	1	1	0	0
Fire related	5	0	0	0	0	0	0	1	0	0
Illness and disease	1	259	13	11	11	8	8	8	14	12
Illness and disease	2	131	4	6	3	5	5	5	9	3
Illness and disease	3	158	6	4	3	8	7	8	7	11
Illness and disease	4	124	4	5	7	6	2	4	3	5
Illness and disease	5	81	6	5	6	3	5	7	2	5
Undetermined including SIDS	1	63	1	1	0	1	0	0	0	0
Undetermined including SIDS	2	16	0	0	0	0	1	0	0	0
Undetermined including SIDS	3	16	0	0	0	0	0	0	1	0
Undetermined including SIDS	4	15	1	0	0	0	0	0	0	1

Category of death	SEIFA disadvantage	0 to 1	2 to 3	4 to 5	6 to 7	8 to 9	10 to 11	12 to 13	14 to 15	16 to 17
Undetermined including SIDS	5	12	0	0	0	0	0	0	0	0
Suicide	1	0	0	0	0	0	0	0	5	5
Suicide	2	0	0	0	0	0	0	1	1	3
Suicide	3	0	0	0	0	0	0	1	3	10
Suicide	4	0	0	0	0	0	0	0	4	5
Suicide	5	0	0	0	0	0	0	0	3	7
Transport related	1	6	5	2	1	3	3	2	4	24
Transport related	2	2	0	0	0	0	2	1	0	8
Transport related	3	2	2	2	0	1	1	3	2	10
Transport related	4	3	4	2	3	3	1	2	3	10
Transport related	5	2	0	1	0	0	1	0	4	7

Data table 8: Number of deaths by age group, category of death and child protection contact status for all children, South Australia 2005-2018

Contact with child protection services	Category of death	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
No family contact with child protection	External causes	2	20	46	22	23	86
No family contact with child protection	Illness or disease	475	133	77	48	58	45
No family contact with child protection	Undetermined including SIDS	7	53	7	1	0	1
Family contact with child protection	External causes	3	9	34	13	27	51
Family contact with child protection	Illness or disease	84	38	30	26	19	16
Family contact with child protection	Undetermined including SIDS	7	44	6	1	1	1

Data table 9: Number of deaths by category of death and cultural background for all children, South Australia 2005-2018

Cultural Background	Category of death	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
Aboriginal	External causes	0	4	9	7	8	20
Aboriginal	Illness or disease	53	23	13	5	10	8
Aboriginal	Undetermined including SIDS	3	15	1	0	0	0
Other	External causes	5	25	71	28	42	117
Other	Illness or disease	506	148	94	69	67	53
Other	Undetermined including SIDS	11	82	12	2	1	2

Data table 10: Death rate by category of death and cultural background for all children, South Australia 2005-2018

Category of death	Aboriginal	Other
External causes	33.68349	5.948342
Illness or disease	78.5948	19.35277
Undetermined including SIDS	13.33305	2.271936

Data table 11: Number of occurrences of ICD-10 chapters by disability status, for all children, South Australia 2005-2018

Disability status	Chapter	Code Range	Number of occurrences of each chapter as the underlying cause of death
Had disability	1	A00-B99	4
Had disability	2	C00-D49	1
Had disability	3	D50-D89	1
Had disability	4	E00-E89	28
Had disability	5	F01-F99	1
Had disability	6	G00-G99	72
Had disability	8	H60-H95	1
Had disability	9	I00-I99	6
Had disability	10	J00-J99	2
Had disability	11	K00-K95	0
Had disability	13	M00-M99	4
Had disability	14	N00-N99	0
Had disability	16	P00-P96	30
Had disability	17	Q00-Q99	147
Had disability	18	R00-R99	3
Had disability	20	V00-Y99	21
No known disability	1	A00-B99	22
No known disability	2	C00-D49	102
No known disability	3	D50-D89	2
No known disability	4	E00-E89	14
No known disability	5	F01-F99	0
No known disability	6	G00-G99	15
No known disability	8	H60-H95	1
No known disability	9	I00-I99	23
No known disability	10	J00-J99	32
No known disability	11	K00-K95	4
No known disability	13	M00-M99	3
No known disability	14	N00-N99	1
No known disability	16	P00-P96	410
No known disability	17	Q00-Q99	95
No known disability	18	R00-R99	117
No known disability	20	V00-Y99	310

Data table 12: Number of occurrences of disability types, for children with a disability status aged 1-17 years, South Australia 2005-2018

Description	Number of deaths
Autism	9
Cerebral palsy	45
Epilepsy	51
Genetic, neurodevelopmental and congenital abnormalities	96
Heart and circulatory abnormalities	16
Intellectual disability	16
Other specified disability	20

Data table 13: Death rate per 10 000 live births by year of death and sex, for children aged less than 12 months, South Australia 2005-2018

Year	Sex	Number of deaths	Death rate per 10 000 live births
2005	Female	37	42.31473
2005	Male	48	51.48557
2006	Female	38	41.58004
2006	Male	25	26.25775
2007	Female	29	30.11735
2007	Male	49	49.02942
2008	Female	28	28.80658
2008	Male	36	35.64709
2009	Female	36	37.94666
2009	Male	33	32.12304
2010	Female	21	21.80233
2010	Male	50	48.77573
2011	Female	29	29.48953
2011	Male	29	27.99768
2012	Female	31	31.12137
2012	Male	25	23.6608
2013	Female	21	21.6987
2013	Male	42	40.20678
2014	Female	25	24.86078
2014	Male	30	28.44141
2015	Female	22	22.55485
2015	Male	31	30.25276
2016	Female	30	31.14295
2016	Male	28	27.18447
2017	Female	29	30.98622
2017	Male	30	30.009
2018	Female	23	27.62431
2018	Male	33	37.82235
2005	Total	85	47.0471
2006	Total	63	33.76206
2007	Total	78	39.74927
2008	Total	64	32.29224
2009	Total	69	34.91903
2010	Total	71	35.7089
2011	Total	58	28.72425
2012	Total	56	27.28114
2013	Total	63	31.3059
2014	Total	55	26.69385
2015	Total	53	26.49868
2016	Total	58	29.09748
2017	Total	59	30.4815
2018	Total	56	32.84072

Data table 14: Number of occurrences of ICD-10 chapters, by age at death for children aged less than 12 months, South Australia 2005-2018

Age group	Chapter	Code Range	Number of occurrences of each chapter as the underlying cause of death
Less than 28 days	1	A00-B99	3
Less than 28 days	10	J00-J99	0
Less than 28 days	11	K00-K95	0
Less than 28 days	13	M00-M99	0
Less than 28 days	16	P00-P96	389
Less than 28 days	17	Q00-Q99	131
Less than 28 days	18	R00-R99	14
Less than 28 days	2	C00-D49	2
Less than 28 days	20	V00-Y99	2
Less than 28 days	4	E00-E89	4
Less than 28 days	6	G00-G99	6
Less than 28 days	9	I00-I99	2
28 days to 365 days	1	A00-B99	13
28 days to 365 days	10	J00-J99	8
28 days to 365 days	11	K00-K95	1
28 days to 365 days	13	M00-M99	1
28 days to 365 days	16	P00-P96	42
28 days to 365 days	17	Q00-Q99	62
28 days to 365 days	18	R00-R99	90
28 days to 365 days	2	C00-D49	3
28 days to 365 days	20	V00-Y99	34
28 days to 365 days	4	E00-E89	8
28 days to 365 days	6	G00-G99	21
28 days to 365 days	9	I00-I99	11

Data table 15: Death rate for children aged less than 12 months by region, who were usual residents and had a definable geographic region, South Australia 2005-2018

SA Government Region	Number of deaths	Death rate per 10 000 resident population
Adelaide Hills	22	21.21563
Barossa, Light and Lower North	33	34.18742
Eastern Adelaide	55	22.48622
Northern Adelaide	224	30.31394
Southern Adelaide	166	29.8008
Western Adelaide	123	37.05086

Data table 16: Death rate for children aged less than 12 months by outer rural region, who were usual residents and had a definable geographic region, South Australia 2005-2018

SA Government Region	Number of deaths	Death rate per 10 000 resident population
Eyre and Western	33	34.68846
Far North	47	98.70072
Fleurieu and Kangaroo Island	27	41.8113
Limestone Coast	42	39.64897
Murray and Mallee	38	36.01889
Yorke and Mid North	32	33.60217

Data table 17: Percentage of deaths involving five unsafe sleeping factors, by each factor, for children aged less than 12 months whose deaths were sudden and unexpected, and occurred after being placed to sleep, South Australia 2005-2017

Category risk	Additional risk	Proportion with this category risk that also have this additional risk
Not placed on back	Not placed on back	1
Not placed on back	Not breast fed	0.3
Not placed on back	Not in an approved bed	0.9
Not placed on back	Bed sharing	0.4
Not placed on back	Parental smoking	0.23
Not breast fed	Not placed on back	0.24
Not breast fed	Not breast fed	1
Not breast fed	Not in an approved bed	0.78
Not breast fed	Bed sharing	0.32
Not breast fed	Parental smoking	0.54
Not in an approved bed	Not placed on back	0.24
Not in an approved bed	Not breast fed	0.26
Not in an approved bed	Not in an approved bed	1
Not in an approved bed	Bed sharing	0.51
Not in an approved bed	Parental smoking	0.44
Bed sharing	Not placed on back	0.21
Bed sharing	Not breast fed	0.21
Bed sharing	Not in an approved bed	1
Bed sharing	Bed sharing	1
Bed sharing	Parental smoking	0.41
Parental smoking	Not placed on back	0.11
Parental smoking	Not breast fed	0.33
Parental smoking	Not in an approved bed	0.81
Parental smoking	Bed sharing	0.38
Parental smoking	Parental smoking	1

Data table 18: Number of occurrences of ICD-10 chapters, for all children, South Australia 2005-2018

Chapter	Code Range	Number of occurrences of each chapter as the underlying cause of death
1	A00-B99	26
2	C00-D49	103
3	D50-D89	3
4	E00-E89	42
5	F01-F99	1
6	G00-G99	87
8	H60-H95	2
9	I00-I99	29
10	J00-J99	34
11	K00-K95	4
13	M00-M99	7
14	N00-N99	1
16	P00-P96	440
17	Q00-Q99	242
18	R00-R99	121
20	V00-Y99	332

Data table 19: Death rate for illness or disease by metropolitan and inner rural region, for children who were usual residents and had a definable geographic region, South Australia 2005-2018

SA Government Region	Number of deaths	Death rate per 100 000 resident population
Adelaide Hills	23	9.972963
Barossa, Light and Lower North	42	19.372721
Eastern Adelaide	73	14.648871
Northern Adelaide	256	19.449648
Southern Adelaide	201	19.116716
Western Adelaide	143	24.211945

Data table 20: Death rate for illness or disease by outer rural region, for children who were usual residents and had a definable geographic region, South Australia 2005-2018

SA Government Region	Number of deaths	Death rate per 100 000 resident population
Eyre and Western	32	16.663707
Far North	58	69.107275
Fleurieu and Kangaroo Island	28	18.885547
Limestone Coast	50	22.901497
Murray and Mallee	50	22.063612
Yorke and Mid North	38	18.088403

Data table 21: Number of deaths from external causes, by age group and sex, for all children, South Australia 2005-2018

COD Category	Sex	Less than 28 days	28 days to 365 days	1 to 4 years	5 to 9 years	10 to 14 years	15 to 17 years
Transport related	Female	2	2	8	9	12	21
Transport related	Male	0	1	17	7	11	47
Suicide	Female	0	0	0	0	2	17
Suicide	Male	0	0	0	0	4	29
Drowning	Female	0	2	11	1	2	2
Drowning	Male	0	1	8	4	2	2
Fire related	Female	0	0	2	0	1	0
Fire related	Male	0	0	4	1	2	0
Deliberate act by another	Female	0	3	7	1	2	4
Deliberate act by another	Male	1	7	12	4	3	2
Accident	Female	0	6	3	4	2	3
Accident	Male	2	7	8	4	7	10

Data table 22: Deaths of children by drowning, by sex and age, South Australia 2005-2018

Sex	0 - 2	3 - 5	6 - 8	9 - 11	12 - 14	15 - 17
Female	13	0	0	1	2	2
Male	8	3	2	2	0	2

Data table 23: Deaths of children by drowning, by location and age, South Australia 2005-2018

Sex	0 - 2	3 - 5	6 - 8	9 - 11	12 - 14	15 - 17
Private	18	2	1	0	2	1
Public	3	1	1	3	0	3

Data table 24: Deaths of children by drowning, by month of death, South Australia 2005-2018

Month	Number of deaths
Jan	7
Feb	5
Mar	2
Apr	3
May	2
Jun	0
Jul	1
Aug	0
Sep	3
Oct	3
Nov	2
Dec	7

Data table 25: Death rate by category of death, for young people aged 15-17 years, South Australia 2005-2018

Category of death	Sex	Number of deaths	Rate per 100 000 of the resident population
Accident	Female	3	0.712781
Accident	Male	10	2.237793
Drowning	Female	2	0.475187
Drowning	Male	2	0.447559
Deliberate act by another	Female	4	0.950375
Deliberate act by another	Male	2	0.447559
Illness and disease	Female	18	4.276686
Illness and disease	Male	43	9.622511
Undetermined	Male	2	0.447559
Suicide	Female	17	4.039092
Suicide	Male	29	6.489601
Transport related	Female	21	4.989467
Transport related	Male	47	10.51763

Data table 26: Populations of South Australian children aged 0 to 17 years from the original sources, and the population 2005-2018 used in this annual report

Year	CDSIRC reporting	ABS Estimate	ABS Census
2005	345883	345883	335820
2006	346257	346257	335820
2007	348320	348320	335820
2008	349864	349864	342210
2009	351475	351475	342210
2010	352848	352848	342210
2011	353001	353001	342210
2012	356153	356153	342210
2013	358110	358110	345928
2014	360720	360720	345928
2015	362992	362992	345928
2016	365622	365622	345928
2017	366307	366307	345928
2018	366636	366636	345928